## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month OCTOBER 2012 7:20 P M KROLL BEVERLY Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GENESIS MULTICARE CENTER TOWSON BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Hours Director 216-16-9012 1 - M 2 X F 89 05/03/1923 NC show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 23a or 28a-f sho ant: If item 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director BALTIMORE 1 ☐ Yes 2 🛣 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2331 OLD COURT ROAD, #410 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) BUSINESS OWNER CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ JACK BENJAMIN ANNE BLOCK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEOFFREY KROLL / SON 25 WOODHOLME VILLAGE COURT, BALTIMORE, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of F Important: If ite any injury or otl once. 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CONG. 10/17/2012 WOODLAWN, MD 21. Signature of Funeral Service Licenso 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Park 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ thrive disease or condition resulting in death) Failureto months Medical Due to (or as a consequence of) Examiner Concer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due for as a consequence of • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ardismyopeth 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural iniury 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Descripting Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10-16-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12V P Genesis Multimedical Center 7700 York Rd. Towson, MD 21204

Registrar DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2012 Yvonne Elaine Levermore 7:52 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shanti House Prince George 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Days Months Hours Country) 146-56-3663 Director 1 🗆 M 2 🕱 F 70 May 11,1942 Jamaica Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any once. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🖾 No MD Howard Laurel 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 9005L North Laurel Road 20723 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black White etc. ģ 1 Mever Married 2 ☐ Married Yes 2 No Baltimore, Maryland 21215-0036 Specify: African-American 1 Yes 2XXNo Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Registered Dietician Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ezekiel W. Levermore Ethel Maud McFarlane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory D. Stokes/ Son 9921 Whiskey Run, Laurel, MD 20723 20a. Method of Disposition 20b. Place of Disposition (Name of October 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 2012 Silver Spring, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee & Ken M01053 313 Talbott Ave., Laurel, MD 20707 23a. PM 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each lin Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Uterine Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical death certificate be Box 68760 as IF FEMALE nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Pregnant at time of death Month Dav ned by the all e detached fo P.O. Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed should 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available has page 2 prior to completion of cause of death? autopsy performed? Yes 2XXNo 1 🗌 Yes 2 K MVc Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 K No မ 4 Mursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 I 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director, After 1XNatural 5 Pending work?
1 Yes 2 No the 2 \( \subseteq \text{ Accident} \) Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D64983

DHMH 17 Rev 06-2011

State Registrar 2101 Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD,

Kashif Alam Firozvi,

October 16, 2012

Park Drive, #200, Silver Spring, MD 20902

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #20b Per FH G933 11/07/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Allen ames 2012 : 49 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner osedale Baltimore Franklin Square Hospital Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 219-62-3197 1 XM 2 🗆 F Director 56 108 MARVIAND 19 56 or 28a-f show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director VORK FREEDOM 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral items 23a 16142 REESE 17349 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces?

1 X Yes 2 No 1973
If Yes, Give
Year or Dates. 1979 Black, White, etc. 1 Never Married 2 Married ò 1 ☐ Yes 2 📉 No Specify: and Mental Hygiene. is marked other than "natural", Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 4.5. post Elementary/Secondary (0-12) College (1-4 or 5+) OFFICE HANDLER Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 LEE CHARIES 1A SUNDERS OR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17349 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health an Important; If item 27 is any injury or other trau once. PATRICIA LEE WIFE RD. NEW ESE PENNSY FREEDOM 10/31/2012 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place A 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12012 OWINGS MILLS, MARYIAND Signature of Funeral Service License 22. Name and Address of FacTATE DERRICK C. JONES FIH, P.A. MARY/And AVE. BALTIMORE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Due to it as a consequence of): disease or condition Medical resulting in death) Examiner 4theroscleros's 04 Cardiovascular if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed pertension Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical roll Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 1 Live Birth 4 Pregnant 9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ate has been signed by the atter page 2 should be detached for i in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☑No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has i autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital Other: ပ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 \( \text{Yes} \) 2 \( \text{No.} \) iniury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number Guongian ctober 14 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive, Baltimore, MD Elizabeth Guonijan 31. Date filed (Month, Day, Year State 8 Registrar

ame

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear Physician/ 8:35 A.M WILMA 2013 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BON SECOURS N/A HUTSPITAL BALTIMOR Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, Year) Oct 20, 1943 1 🗆 M 2 💆 F NC 219-50-5693 68 Director or 28a-f show notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland Director 1 Yes 2 □ No **Baltimore Baltimore City** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 "natural", or items 23a or Funeral 1224 Carroll Street 21230 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 X Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Specify Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **Dorothy May Lofton** James Lofton 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Lofton 1224 Carroll Street Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Western Cemetery Oct 18, 2012 Baltimore, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the usease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of). Phylician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Pulmonary and use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Pregnant at time of death Other (specify) signed by the at d be detached fo Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 After this certificate 1 Yes 2 No Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 2 1 No 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 🗌 No 24 hours after death. Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2. 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 72516 0/08/2012 se of death (Hem 23a) (Type, Print) 30. Name and address of

DHMH 17 Rev 06-2011

State Registrar Registrar's Signature

12-07696	
UNK UNK	5

	1Ki	a moria			(9)	
9-07696	M	Please Type or Print in Black Indelible Indeli				
		1- For State Certificate of L			g. No. 201	2 3350
Physic edical Exam		Decedent's Name (First, Middle,Last)		2. Date of Death Month October 11		3. Time of Death 0300 hrs
edical Exam		TAMA TURKITI TOTAL	City, Town, or Location of Dea		4c. County of Death	
			Baltimore			,
Funera Directo			If Under 1 Year If Under 24H Months Days Hours Mi	_	(MM/DD/YYYY) 9. Birth 2005 Foreign Cou	
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	g _	MD BALTIM	RE			1 X Yes 2 No
with the Maryland ns 23a nr 28a-f show	Director		Of. Zip Code	10	g. Citizen of What Coun	ry?
ith the 23s or	a D	5601 DEN WOOD  11. Marital Status  12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 1	21206 ecedent of Hispanic Origin? ( \$	Specify Ves or No-	USA 14. Race - Americ	an Indian Black
eath w	Funeral		specify Cuban, Mexican, Puerl		White, etc.	arr molan, black,
after d		3 Widowed 4 Divorced If Yes, Give Year or Dates:	es 2 🔀 No specify:		Specify: BLA	
2 hours.	ted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	Usuał Occupation (Give kind of of working life. DO NOT use re		16b. Kind of Business/In	dustry
5-0036 led within 72 hours al Hygiene. Inther than "natural the Medical Examin	Completed	2 STU	DENT  18.Mother's Nam		STUDE	NT
21215-0036 July be filed within 73 Mental Hygiene, marked other than	Be Co	17. Father's Name (First, Middle, Last)  JOSEPH MILLS	18, Mother's Nam	ne (First, Middle, M. WORKE	aiden Surname)	
	ToB	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing A	dress (Street and Number or	Rural Route Numb	per, City or Town, State,	Zip Code)
		LAKIA WORRELL MOTHER 347 E  20a. Method of Disposition 20b. Place of Disposition	1. 27 <sup>th</sup> ST. Br	ALTIMOre	, Md . 217	206
Baltimore, Moemit Pages 1 and 2 Oppartment of Health Important I fitem 2		1 Burial 2 Cremation 3 Removal from State crematory or other	place)	ماريداري	RAJIMOI	ee, Md
Baltimo permit. Page Department ( Important:		4 Donation 5 Other Specify:  21. Signature of Funeral Selvice Licensee  22. Nan	Place) 4 LLEY e and Address of Facility VA	AUGHN GR	EENE FUNER	AL SERVICE
Balt permit Depart Import		Vaugha C IL 491	5 YORK ROAD.	BALTIM	ORE, MD.	21212
Physicia:		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	node of dying, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
Examine	r	Immediate Cause (Final disease or condition resulting in death)  a. Smoke Inhalation and Thermal Injurie Due to (or as a consequence of):	:S			Deali
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	caminer	Cause. Enter Underlying Cause (Disease or injury that initiated				
cecuted and and - transit	û	events resulting in death) Last  Due to (or as a consequence of):  d.				
e execute cian and rial - tran	dica	UNPENDED AMENDED				
18760, tificate be exing physician as the burial	S S	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1   Live birth 2   Fetal	death 3 Ectopic pregr	nancy	23d. Date of delivery  Month Da	av Year
endi	3	past 12 months?  4 Pregnant at time of death 5 Other	(Specify)			,
O. B. the dear by the s	Phy	Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I.	23e. Did tob	pacco use contribute to the	ne cause of death?
tal Records, P.O. Box cian: The law requires that the death certificate has been signed by the att	ā p			1 Yes	2 No 3 Proba	ibly 4 🗹 Unknown
ords w requ	plete			24a. Was ar autops	y prior to co	opsy findings available impletion of cause of
Rec The la ficate h	Completed			perform 1 ✓ Yes 2	ned? death? ☐ No 1 ✔ Yes	2 No
of Vital Records, og Physician: The law require ther this certificate has been sineral director nase 2 should here of should be the second of the control of		25. Was case referred to medical examiner?   Hospital: 1   Inpution: 2   ER/Outpatient: 3	26.Place of Death (Check		Residence 6 🗸 Other:	Scene
n of Vital ling Physician: After this certif		27 Manner of Death 290 Date of Injury 29h Time of Injury	y 28c. Injury at Work?		ow injury occurred	
Division tal or Atteodius after death.	gie	1 Natural 5 Pending PoUND: FOUND: Oct 11, 2012 FOUND: 0206 hrs	1 Yes 2 No			I Do to Market Oil
Division or a safter ral Direction of the control o	Certification:	3 Suicide 6 Could not be determined (Specify) Townhouse / Rowhouse	actory, office building, etc.		reet and Number or Rura ate)   Road, Baltimore, MD	
Division of Note the Hospital or Atteoding Physhin 24 hours after death. To the Funeral Director: After to Completely filled in by the fineral	calc	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred one)  2 Medical Examiner: On the basis of examination and/or investigation	at the time, date and place, an	nd due to the cause	(s) and manner as stated	d.
To th	Medical	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mont	
		his he is	O.C.M.E.		October 11, 2012	
l v		30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 900 W. Baltimore	Street Baltimore MD 3	1223		
	State			.1220		
Regi		31. Date filed (Month, Day Xear) 12. Registrar's Signeture (Month) Repair				

OGME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCT. 20<sup>Year</sup>2 Dorothea Marie Meile 10:30AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunflower Hill Asst. Carroll Living Westminster Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral Days Hours (Month, Day, Months Min. 220-14-7978 Director 1 M 2 F 91 Yrs MD Usual Residence of Decedent or then "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Carroll MD Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21158 USA 707 Uniontown Rd. 12 Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 ZNo Specify: Specify: white Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Housewife e 1 and 2 should be filed wit of Heelth and Mental Hygie If item 27 is marked other ir other treumetIc event, III Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mildred Harrison Frank Farinholt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
707 Uniontown Rd., Westminster, MD 21158 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Heelth ar Important: If item 27 is any injury or other treu Juanita D. Zepp-daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🏝 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/22/12 Zion Cemetery Westminster,MD 22. Name and Address of FacilityFletcher Funeral & Cremation 21. Signature of Funeral Service Licensee T Main St., Westminster, MD 254 E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami The law requires that the death certificate be executed ng physician and as the burial-transit Due to (or as a consequence of resulting in death) Last Physician/Medical Box 68760 attending I for use as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) Yes 2 No detached 9 Unknown 9 Unknown P.0. à signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has build in the control of the control autopsy performe 1 Yes 2 No 1 ☐ Yes 2 ☐ No **Division of Vital** Hospital or Attending Physicien: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify မ 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun Natural Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and address of person who complete cause of death (Item 23a) (Type, Pring Mitdletonmo 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. lend #26 Per VERB 932 10/18/2012 JH
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 1:00 2012 Oct Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3007 Dunmurry Rd. Dundalk Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) March 8, Davs Hours Country 215-48-4899 Director 1 □ M 2 🛛 F 61 1951 Md. Usual Residence of Deced permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Director Md. Baltimore Parkville 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 3117 Rosalie Ave. 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 specify: White 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Pediatric Assistant Health Care 12 vrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cecila Bernice Mecinski John Francis Iwanowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Mentzer 3123 Dunglow Rd. Dundalk Md. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Oct. 17 2012 1 Burial 2 X Cremation 3 Removal from State Baltimore Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signe ture of Funeral Service License 22. Name and Address of Facility | Home Of Dundalk 7110 Soilers Point Rd. 21222 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ Due to (or as a consequence of): years disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be rriend s examiner? Other: 4 Nursing Home 5 The Sidence 6 To ther (Specify) 2 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA House 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 D Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier VI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 | 3 | only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 10/16/2012 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7501 OSLER RIMA 40 COU 10WSDN 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 18 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1428 Eugene Joseph Marshall 2012 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HICOMICO KIGIDIAL MADICE Centu TENINSKLA SALISBURY 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) 218-36-2108 Days Director 1 🔀 M 2 🗆 F Aug. 1, 1938 74 Maryland Usual Residence of Deceden 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Directo Delaware Sussex Ocean View 1 ☐ Yes 2 🏝 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5 Avondale Drive 19970 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 XMarried ð Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) District Court of Elementary/Secondary (0-12) College (1-4 or 5+) Court Commissioner e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 Is marked other: Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H Is marked of Joseph C. Marshall Margaret M. Bowling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Avondale Drive; Ocean View, Delaware Frances J. Marshall Wife 19970 Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o Page 1 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park: 10/19/2012 Elkridge, MD 22. Name and Address of Facility Gary L. Kaufman Funeral Home at Meadowridge Memorial Park 7250 Washington Blvd., Elkridge, MD 21075 Signature of Funeral Service Licensee Hademan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between 4 Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events Dun to for as a consequence of: sician and burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical Box 68760 the th as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month 5 Other (specify) Day Yes 2 □ No detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Records, Completed been sign 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗙 No 은 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at After t 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A
completely filled in by the f 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 30. Name and address of person who over pleted cause of death (Item 23a) (Type, Print) Deer 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 18 20 Registrar

8:00 P

Birthplace (State or Foreign Country)

White

Approximate Interval Between Onset and Death

10d. Inside City Limits

1 ☐ Yes 2X No

Maryland

14. Race - American Indian,

Black, White, etc.

Specify.

Month

death? 1 ☐ Yes

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of

2□ No

2012

State Registrar

Medical

29a. Certifier (Check only one)

29b. Signaturg and title of certifier

am

Sa) (Type, Print) Lel on 4107 Cotmor/le MD 2127 31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 1 8 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(m)

1/01

**ORIGINAL** 

Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Stephen Franklin Macadoff Month October 2012 4:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 10489 Gorman Road Laurel Howard Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Months Days Min (Month, Day, Year) **Director** 220-60-0852 1 XM 2 F 59 Yrs Aug. 30, 1953 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director MD Howard Laurel 1 Yes 2X XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10489 Gorman Road 20723 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 X No Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced Completed white the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Assistant Professor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stephen Macadoff Catherine Marie DeMarco should to and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Sandra L. Macadoff/ Wife 8351 Sperry Court, Laurel, MD 20723 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 16 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 2012 Odenton, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01053 313 Talbott Ave., Laurel, MD 20707 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, swock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Metastic Lung Cancer years Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 the as attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) Pregnant at time of death 2 🗌 No ed by the a 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 X No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law has page 2 autopsy performed? certificate 1 Yes 2xxNo Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home XX Residence 6 Other (Specify) 2XXNo 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier X 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Somme Catalano HOO 40518

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lenen S. parket

Bonnie Catalano, DO, 5450 Knoll North Dr., Suite 250, Columbia, MD 21045

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month October 2012 Kenneth MacDonald 2:25 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Care Columbia Howard Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Days Hours Director 080-32-6302 1 🛛 M 2 ☐ F 79 July 13,1933 Scotland or 28e-f show and Mental Hygiene. is marked other than "natural", or items 23a or 28e-f shoven eumatic event, the Modical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Manyland ment of Heelth and Mental Hygiene. eart if ifem 27 is marked other than "natural", or items 23a or 28e-f shoury or other treumatic event, if a Maches items to be notified at ury or orther treumatic event, if a Maches item. 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2 No Prince George Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9276 Cherry Lane #83 20708 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Heating Engineer Utility Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Alex MacDonald Ellen MacDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vera V. MacDonald /spouse 9276 Cherry Lane # 83, Laurel, Maryland 20708 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of F Importent: If ite eny injury or ot once. Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Mary's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Oct 20, 12 Laurel, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Donaldson Funeral Home, P.A. 313 Talbott Ave., Laurel, Maryland 20707-4389 M00773 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or bean failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ GLIOBLASTOMA NULTIFORME disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the a completely filled in by the funeral director, page 2 should be detached for 9 Unknown 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 █ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: ၉ 1 Tes 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number

State Registrar

0

Q. 31. Date filed (Month, Day, Year)

ABBAS

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

b72139

LANE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTO BERDAY 16 16 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death Washington Medical Center Glen Burnie Hnne If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 212 42 6115 **Director** 1 X M 2 D F 66 07/04/1946 West Virginia show 10c. City, Town or Location filed within 72 hours after death with the Maryland must be notified at 10d. Inside City Limits Director 28a-f Maryland Anne Arundel Severn 1 Yes 2 X No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1628 Shannon O Circle 21144 U.S.A. "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: 3 X Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed 8th Taxi Cab Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Buster McElroy Mabel Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joy Hurd / Friend 469 Glen Mar Road Apt. C2 Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 10/18/2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. mamueau 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or a a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy jo in the past 12 months? Pregnant at time of death Other (specify) Month Day Year signed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has I completely filled in by the funeral director. autopsy 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 Yes Certificate: 27. Manner of Deat Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending iniurv Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practition : p the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) altimore Washill 461 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

ORIGINAL

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 020 +1 1107 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death OPPET Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Furieral** (Month, Day, Year) Oct 30, 1931 509-26-0585 80 Months Days Hours Min. Kansas Director 1 🗆 M 2 🜠 F Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits 10c. City. Town or Location the Medical Examiner must be notified at Director MD Carroll Westminster 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 941 Westcliff Court 21158 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 5 ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 73 th and Mental Hygiene.
27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Wesley Abrum Siegrist Blanche Ellen Measer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Moxley : Page 1 and 2 sl tment of Health a tant: If item 27 is cousin 13205 Route 144 West Friendship, MD 21794 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 🗹 Burial 2 🗌 Cremation 3 🗌 Removal from State Oct 23, 2012 Crest Lawn Memorial Gardens Marriottsville, MD onation 5 Other (Spealty) 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Signature of Funeral Service of limberle Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between mmediate Cause (Final disease or condition Onset and Death Physician/ Stage Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? Yes 2 A No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1. Natural 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and n ddress of person who completed cause of death (Item 23a) (Type, Print) MD 1645 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

ORIGINAL

Box 68760 Division of Vital Records,

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	for State Registrar	State of Ma		artment of I <i>rtificate of</i> I	Health and N <i>Death</i>	/lental Hy	giene 2	012	3351	4
Physician/	Decedent's Name (First, Middle	,				2. Date of De	eath	Year	3. Time of Death	_
Medical Examiner	Freda Mahala M  4a. Facility Name (if not institution			4b City Town o	or Location of Death	Octob		2012	9:20 P <sup>M</sup>	
Examiner	1117 Agnew Dri			Rockv				atgomer	·y	
Funeral Director	5. Social Security Number 191–18–9505	6. Sex 7. Age (	In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth ay, Yea <i>r</i> )	9. Birthpla Country	ace (State or Foreign	_
	Usual Residence of Decedent		98 Yrs.			Sept.	1, 1914	Penns	ylvania	
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.  To Be Completed by Funeral Director	10a. State 10b. County		IOc. City, Town or L					10	d. Inside City Limits	
or 28a-f sho i notified at Director	Maryland Montg	omery	Rockvill	e 10f. Zip Code	<del></del>		10 02	()All - 1 C - 1	1 X Yes 2 No	_
items 23a o ner must be Funeral I	1117 Agnew Dr	ive			0851		10g. Citizen o	d Stat		
Fun	11. Marital Status	12. Was Decedent Eve			Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No-	14. Ra	ace - America	n Indian,	_
Examin ed by	1 🛛 Never Married 2 🗆 Ma	rried 1 Yes 2 X No	0	1 Yes 2 X No		nicari, etc.)	Speci	ack, White, et <sup>fy:</sup> Whi		
the Medical Exa	15. Decede (Specify only high	nt's Education est grade completed)	(Give	dent's Usual Occup kind of work done	during most of work	ing	16b. Kind of	Business/Indu	ıstry	_
8		College (1-4 or 5+)		00 NOT use retired, intant			Accou	nting		
. Be		Last)			18. Mother's Nam	e (First, Middle,				_
10	rreeman narpny				Freda Bu	ırke				
	19a. Informant's Name/Relations Robert Taylor		1		and Number or Rura				*	
	20a. Method of Disposition 1 ☐ Burial 2 🎖 Cremation		20h Place of Disp			Date	T	n - City or Tow		_
la i	4 Donation 5 Other (	Specify)	Cremator	ium, Inc.	18.	2012	Bethes			
ouce	21. Signal of Feyeral Service	_	01619 R	<sup>2. Name and Addre obert A. <u>00 West M</u>e</sup>	Pumphrey ontgomery A	Funera	1 Home, Rockville	Rockv	ille, Inc. land 20850	
		r complications that caused the only one cause on each line.							Approximate Interval Between	
ian ical	Immediate Cause (Final disease or condition resulting in death)	a. My 0	cardi	al I	harc	tim.		(	Onset and Death	ï
iner		Due to (or as a c	consequence of);	- Jen	, 'Q'.	ieas	-6			
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c	onsequent e of).	1 101	1					ï
Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	onsequence of):					-		())
edical Exami		C <sub>d</sub> .								
	IF FEMALE:								_	_
Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1  Live Birth 2 4  Pregnant at ti	Fetal death 3	Ectopic pregnan	су			ate of deliver	y Day Year	
hysid	1 Yes 2 No 9 Unknown	9 Unknown	me or death 5	Other (specify)					ray roa	
leted by Physi	Part II. Other significant conditi	ons contributing to death but	not resulting in the	underlying cause gi	ven in Part I.	23e. Did t	obacco use co	ntribute to the	cause of death?	
eted			<u>.</u>			1 🗆	Yes 2 No	3 Proba	ably 4 Unknown	
Completed						24a. Was auto			sy findings available pletion of cause of	
Be Co	25. Was case referred to medical	1		26 P	lace of Death (Check	1 Yes	2 X No	1 ☐ Yes 2	□ No	
으	examiner? 1  Yes 2 No	Hospital: 1  Inpatient	2 ER/Outpatie	Oth		- 4	dence 6 🗆 Ot	her (Specify)		
喜	27. Manner of Death  1 Natural 5 Pendi 2 Accident Invest		/ear) 28b. Time o	work	y at		how injury occu			
Certificate:	3 Suicide 6 Could 4 Homicide detern	not be	- At home, farm, st Spec <i>ify)</i>			28f. Location (	Street and Num vn, State)	ber or Rural R		
ं ल	29a. Certifier 1 X Certifying	Physician: To the best of my	/ knowledge, death	occurred at the tim	e, date and place, ar	nd due to the c	ause(s) and ma	nner as stated	1.	J.S
completely filled in by the fu	(Check 2 L Medical I	xaminer: On the basis of exam Nurse Practitioner: To the b	mination and/or inve	tigation, in my opini	on, death occurred at	the time, date a	and place, and d	lue to the caus	e(s) and manner states	d.
	29b. Signature and title of certifie			29c. Licens	e number		29d. Date sign	ed (Month, Da	ıy, Year)	
	20 Name and Advance of payment	A	14 (44 - ) 00a) (Fina	100	6349		10.	-11-	. 12_	_
	John E. Kelly,				, Rockvil	le, Mar	yl <i>e.</i> nd	20850		
State istrar	31. Date filed (Month, Day, Year)	32. Penistrar's	Signature				· · · · · · · · · · · · · · · · · · ·			
ev 06-2011	OCT 18	2012 Shows	J. A	ale	<u></u>					_
2. 00 2011										

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene  $2\ 0\ |\ 2$ For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Virginia Kay Miller 10712/2012 6:50 pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loca Elkton or Location of Death **Examiner** 247 Sycamore Road Cecil If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 0277971971937 219-34-6388 MD Director 75 Usual Residence of Decedent "natural", or items 23a or 28a-f show 10b. County 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** Lavale Allegany MD 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 12414 Butler Drive USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc 1 Never Married 2 Married Completed by White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

16a. Decedent's Usual Occupation
16a. Decedent Usual Occupation
16a. Decede 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) life. DO NOT use retired) Homemaker Elementary/Seconday (0-12) Homemaker To Be 18. Mother's Name (First, Middle, Maiden Surname)

Mae Smith 17. Father's Name (First, Middle, Last) Richard Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 247 Sycamore Road Elkton MD 21921 Jody Quiros 20a. Method of Disposition
1 ☐ Burial 2 ☐ Kremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place Atlantic Crem 10/16/12 Glen Burnie MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv 21. Signature of Funeral Service Licensee ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Adenocaecinau disease or condition resulting in death) There years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? DA-Shter. Hospital: Other: မ 1 🗌 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Spec 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No ☐ Accident Investigation after death 6 Could not be Suicide To the Hospital or Atta within 24 hours after de To the Funeral Directo completed filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ogletown RCI 4201 STANKON K. Suppian OCT 18 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2327 4 20/2 ames Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. Months 1 X M 2 🗆 F Days Hours 217-40-7448 68 Director Yrs MD Jun 17, 1944 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 23a or 28a-f sho important: If item 25 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No **Baltimore City Baltimore** MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3001 Stranden Road 21230 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Seafood Preparer Food King 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James West Jannie McAllister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claretha McAllister 3001 Stranden Road, Baltimore, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State tery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Oct 20, 2012 Mt. Zion Cemetery Lansdowne, MD 4 Dopation 5 Dopation 5 Other (Specify) 22. Name and Address of Facility

Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 Tun ral Service License Signature Part 1. 5 fer the disease, or complications that caused the death of enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ Voca Chorc disease or condition resulting in death) Medical Due to or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Cancer Box 68760 IF FEMALE nse yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Dav Pregnant at time of death Other (specify) Unknown P.O. s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy Yes 2 N Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: ည 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No after death.

Director: Af Accident Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) Type, Pr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Walter H. Morse 5:10 am October 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 065-22-8617 1 **X** M 2 □ F 85 July 25, 1927 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Rockville 1 🗌 Yes 2 💢 No Maryland Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20852 U.S.A. 6121 Montrose Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 X No 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Specify: Caucasian Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Government Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Beniamin Morse Minna Wallach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Minna Morse - Daughter 4404 Yuma Street, NW, Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 X Removal from State Donation 5 Other Spacify) Cedar Park Cemetery 10/18/2012 | Paramus. New Jersey 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Signature of Funeral Service Libensee M00709 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death disease or condition resulting in death) Cholecystiti Aspiration Pneumonia Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death 9 Unknown

Physician/ Medical Examine

Department of Important: If it any injury or o

Physician/

Medical

Examiner

**Funeral** 

Director

28a-f show

0

23a

9

"natural",

Il Hygiene.

and Mental !

Baltimore, Maryland 21215-0036

must be notified at

Examiner

Medical

the

other traumatic event.

Director

ģ

Completed

Be

ပ

and attending physician for use as the buria signed by the a certificate has funeral director, after death.

Director: After this the Hospital or Attending within 24 hours a

Division of Vital Records,

Morse

Nalter

Physician/Medical ģ Completed Be Certificate: Medical

(Check

29b. Signature and little

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Tibula-Fibular Fracture Myocardial Infarction 24a. Was an performed: 25. Was case referred to medical 26. Place of Death (Check only one) 1 X Yes 2 □ No Hospital 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1X Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

10 V

of death (Item 23a) (Type, Print) 30. Name and address of person who complete

M.D., &b00 Old Georgetown Road, Bethesda, Maryland 20814 Anitha Chetty,

State Registrar Gertifying Nurse Practitioner: To the best of my knowledge

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 335 | 8

itthev	v Morrov	٧	1- For State	ate of Maryl		artment of rtificate of		and	Menta	l Hy		eg. No.		
	Physici	an/	Registrar  1. Decedent's Name (First, Midd	le,Last)						2	2. Date of Deat	th		3. Time of Death
edica	l Exam	iner	TIALLITEW	Morrow							Month October 1			0232 hrs
			4a. Facility Name (if not institution  Baltimore Washingtor		•	4	b. City, Tow Glen Bu		ocation of I	Death		4c. County Anne Ai		
			5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday/	If Under 1		If Under 2	2/Hre	8 Date of Bir			thplace (State or
	Funeral Director		220–29–9305	1 X M 2 F	21	Yrs.	Months	Days	Hours	Min.	11/13/	•	Foreig	gn
	_		Usual Residence of Decedent				11				111/13/	1990	1	Maryland
	r death with the Maryland or items 23a or 28a-f show any must be notified at once.		10a. State 10b. County	o A 1 - 1		, Town or Locati	on							10d. Inside City Limits  1 Yes 2 XNo
	Pages 1 and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygievite with the Mental Hygievite with "matural", or items 23a or 28a-f she use if item 27 is marked other than "natural", or items 23a or 28a-f she ir other traumatte event, the Medical Examiner must be notified at once	Director	Maryland Anno	e Arundel	Pasa	adena	10f. Zip Co	ode			1	Og. Citizen of W	hat Cou	
;	the M	Dire	681 Duvall Hig	hway			211	22				IJ.	S.A	_
	ms 23 be no	eral	11. Marital Status	12. Was De	ecedent Ever in U		Decedent	of Hispa			cify Yes or No	14. Race	- Amer	ican Indian, Black,
	or ite	Funeral	1 X Never Married 2 M	1 Yes	2 No		es, specify C			uerto R	ican, etc.)		e, etc.	
	rs afte rral", niner	Š	3 Widowed 4 Div	orced If Yes, Give Ye or Dates:		16a. Decedent	Yes 2 X			d of wo	rk done	Specify: 16b. Kind of Bu		
	"natr	Completed	Elementary/Secondary (0-12)		(1-4 or 5+)		st of workin					TOD. KING OF BO	231116331	industry
036	thin 7 ne. r than redica	혈	12	2		5	tuden	t					Stud	iont
21215-0036	Id be tiled within 72 hours after dental Hygiene. narked other than "natural", event, the Medical Examiner		17. Father's Name (First, Middle,			<u> </u>	caacii	18	.Mother's I	Name (I	First, Middle, N	/aiden Surname	)	K.III.
121	uld be fu Mental F marked c event,	Be	Edward L.  19a. Informant's Name/Relations	Morro	W				Carla		<u>C.</u>	Schmi	dt.	
D 2	shoul and M 7 is m	욘	Edward & Carla		Donont -							ber, City or Tow		
e, MD	I and 2 should be filed within Health and Mental Hygiene. item 27 is marked other it raumatic event, the Med		20a. Method of Disposition	MOTTOM (	20b.	Place of Disposi	tion (Name	H19 of ceme	tery,	Pas	<u>sadena.</u> Date	Maryla 20c. Location	<u>nd</u> ∠ - City or	Z <u>IIZZ</u> Town, State
Baltimore,	permit. Pages I Department of F. Important: If i Injury or other		1 Burial 2 X Cremation		TOTT State	crematory or oth Lantic C		ian		10/1	10/2012	C1 P		M 1 :
atin.	artme		4 Donation 5 Other States 21. Signature of Juneral Service		00-732				f Facility_	10/	10/2012	Gren b	urn	ie, Maryland
m	Per D be		ATI	L	.00 /32	McC 320	ully- 4 Mou	Poly ntai	yniak in Ro	Fur ad F	peral H Basaden	ome, P. a. Mary	A. Iano	1 21122
	ysician		23a art I. Enter the disease, or failure. List only one cause		caused the death	n. Do not enter th	e mode of d	lying, su	uch as card	liac or r	espiratory arre	est, shock, or he	art	Approximate Interval Between Onset and
	ledical aminer		Immediate Cause (Final disease	<sub>a.</sub> Multiple G										Death
	:		or condition resulting in death)	Due to (or as	a consequence o	of):								
		ner	Sequentially list conditions, if any, leading to immediate		a consequence o	of):				-				
		ami	cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as	a consequence o	of):						-		
	recuted and transit	dical Examine	events resulting in deathy Last	d		,								
,	be exe	dica	UNPENDED	AMENDED										
Box 68760	g physics of the burner of the	Physician/Me	IF FEMALE: 23b, Was decedent pregnant in th	23c. If yes,	outcome of preg		al death	3	Ectopic pr	regnand	ev.	23d. Date of Month		/ Day Year
39 X	eatn certific e attending p for use as th	icial	past 12 months?	4 Preg	nant at time of de		er (Specify,		JEOLOPIO PI	ognan	.,	Worlds		Jay Tou
B B	the at	hys		g Unkr							Tanana			
sion of Vital Records, P.O. Box 68760,	signed by	ρ	Part II. Other significant condit	ions contributing t	to death but not r	resulting in the u	iderlying ca	use give	en in Part I		_			the cause of death?  Dably 4 Unknown
ds,	equire seen si ould b	Completed								_	24a. Was a			topsy findings available
of Vital Records,	e iaw i e has t ge 2 sh	шb						_		_	autop	med?	leath?	completion of cause of
R.	certificate has ector, page 2 s		25. Was case referred to medical	<u> </u>			26.	Place of	Death (Ch	neck on	1 Yes 2	2 No 1	<b>✓</b> Ye	es 2 No
Vita	nystem this cer il direct	o Be	examiner? 1 ✔ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient		LOH	hor:			Residence 6	Other	:
of	After t	-	27. Manner of Death	28a. Date	e of Injury h. Day Year) 2012	28b. Time of In	jury 28c.	. Injury a	at Work?		8d. Describe h ubject was	ow injury occurr	ed	
ion	death. tor: / the fi	atio	1 Natural 5 Pend 2 Accident Inves	ding Oct 13,	2012	0128 hrs	1	Yes	s 2 🗸 No		ubject was	51101		
<u>`</u> ⋝ ≀	in Pig in	Certification:	deter	a not be	ce of Injury - At h		, factory, off	fice build	ding, etc.	- 1	or Town, St	ate)		ral Route Number, City
	hours uncra		4 Momicide  29a. Certifier	(0,000)	Local Stre		ad at the tim	na data	and -loss	_		eet, Pasadena		
1	vithin 24 h To the Fur completely	Medical	(Check only one) 2 Medical Example 2	hysician: To the be miner:On the basis	of examination a									
F	To COII	Me	29b. Signature and title of certifie	and manner :	stated.		29c. Li	cense n	number			29d. Date sign	ed (Moi	nth, Day, Year)
			Juma 8	rethall.	mi		0	C.M.	E.			October 13	3, 2012	2
3	v I		30. Name and address of person				1A/ D "					222		
J		tate	Pamela E. Southall, M		Medical Exa	uro.		nore S	Street, E	aitim	ore, MD 21	223	_	
	Regis		31. Date filed (Month, Day Year)	3 2012 32. 5	neva	3. par	Nes!							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JOHN MILDENBERG 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GLEN BURNTE, MO BALTIMORE WASHINGTON MEDICAL ANNE ARUNDEL CERTER 21061 If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Director 1 🕱 M 2 🗆 F March 28, 1931 Maryland 81 28a-f show 10b. County 10d. Inside City Limits 10c. City. Town or Location Examiner must be notified at Director Baltimore N/A Maryland 1 4 1 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ы Funeral items 23a 21230 1723 Covington Street USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian Armed Forces?
1 

Yes 2 □ No Black White etc. "natural", or by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give White 3 X Widowed 4 Divorced Completed Year or Dates. other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry and Mental Hygiene. is marked other than life. DO NOT use retired) I.L.A. Elementary/Secondary (0-12) College (1-4 or 5+) Longshoreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Joseph Mildenberger Elizabeth Frankowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau once. (Son) 1723 Covington St., Baltimore, Maryland 21230 David John Mildenberg 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date cemetery, crematory or other placedar Hill Cemetery 1  $\square$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State Baltimore, Maryland 10/22/12 4 Donation 5 Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kevin E Ecker 21230-4513 MOO175 130 East Fort Avenue, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ MYSCARDIAL disease or condition resulting in death) INFARCTION Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as t 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No for Pregnant at time of death Unknown 9 Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown YPERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: after death. Director: After (Month, Day, Year) 1 X Natural 5 Pending work?
1 Yes 2 No М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. HOSPITAL GLEN BURNIE 31. Date filed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 12, 2012 8:30 George Vassilis Nicolaras Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days Hours (Month, Day, Year) 119-34-6638 **Director** 1 M 2 □ F 90 April 21, 1922 Egypt Usual Residence of Decedent 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director 1 Ves 2 X No Maryland Montgomery Rockville 10e. Street and Number 10g. Citizen of What Country? Funeral 20886 8516 Tindal Springs Drive United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 3 Divorced White Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Purchases Payable Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Department 12 Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maria Kotsoflorou Vassilis Nicolaras 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19923 Silverfield Drive, Montgomery Village, Maryland 20886 Helen N. Pastis /Daughter permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 19 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery Dagsboro, Delaware 4 Donation 5 Other (Specify) 2012 Signature of Funeral Service Licensee 22 Name and Address of Facility Funeral Home/Rockville, Inc. M01305 lette Marul 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 11-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Failure Physician 9551 disease or condition resulting in death) 011 atory Medical Due to (or a a consequence of) Examiner assive chemic Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Pora Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy for in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 ☐ No the a filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) of Vital examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Ninpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🗷 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Division ☐ Accident
☐ Suicide Investigation 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical within 24 hound to the Funer completely file 29a. Certifier 1 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Drive Rockville viHona MD 20850 990 Medical ana State 1 8 2012 Registrar

DHMH 17 Rev 06-2011

0

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death October Physician/ 2012 8:25 PM OLIVER ALBERT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Regional Hospital Laure If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Min (Month, Day, Year) 207-05-3889 Director 1 🖾 M 2 🗆 F Jan 20, 1918 Pennsylvania Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Examiner must be notified at Director 1 X Yes 2 No MD Prince George Laurel or, 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 605 4th Street 20707 U.S.A. or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White and Mental Hygiene. is marked other than "natural", 3 ☐ Widowed 4 ☐ Divorced Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) District of Columbia Elementary/Secondary (0-12) College (1-4 or 5+) Government 5+ Superintendant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Alfonso Oliver Nancy Chaump 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sk Department of Health a Important: If Item 27 is any injury or other tra Rachael R. Oliver / spouse 605 4th Street, Laurel, Maryland 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory Oct 19, 12 Odenton, Maryland 21. Signatury of Funeral Service License 2 Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave., Laurel, Maryland 20707-4389 Will M00773 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of) **Examiner** Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Acute Rend -ailur ysician and e burial-tran Due to (or as a consequence of) Physician/Medical P.O. Box 68760 s the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Congestive Heart Failure Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s has autopsy perform certificate 2 🗆 No Yes 2 X No 1 Tes Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 🗙 No Other: 1 Yes ျ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending death. 1 Yes 2 No Accident Investigation Funeral Director: A etely filled in by the 2 ☐ Acciden 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hou

To the Fune

completely fi (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and 29d. Date signed (Month, Day, Year) D55861 October 14, 2012 NO mes حماد 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Dusen Road MD Laurel Regional Hospital Munim, durel Registra State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 12. 2012 Shantaben D. Patel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1924 Eamons Way Anne Arundel Annapolis Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Min. 218-90-1693 96 1 M 2 X F September 10,1916 India Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral 1924 Eamons Way United States 21401 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 X No Specify Specify: Asian Indian Completed 3 Wildowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Deviben Patel Raghabhai Patel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1924 Eamons Way, Annapolis, Maryland, 21401 Amrut Patel/Son 20a. Method of Disposition 20b. Place of Disposition (Name o 20c. Location - City or Town, State cemetary crematory or other place West Arundel Crematory October 14, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Odenton, Maryland 21. Signature of Funeral Service Licensee Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 MO1386 23a. Part 1. Enter the disease, or compli-shock, or heart failure. List only one inclications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Interval Between Onset and Death Immediate Cause (Final Coronary Disease Years disease or condition resulting in death) Due to (or as a consequence of)

Physician/ Medical Examiner

**Funeral** 

Director

show

28a-f

items 23a or ner must be n

r than "natural", or iter the Medical Examiner

and Mental H

permit. Page 1 and 2 should be Department of Health and Ment Important: If Item 27 is marke any Injury or other traumatic.

hours after

Baltimore, Maryland 21215-0036

notified at

Box 68760 P.O. by Records, has Hospital or Attending Physician: The Division of Vital

Examiner Be Completed by Physician/Medical 2 Certificate: Medical

only one) 29b. Signature and title of ce

31. Date filed (Month, Day, Year)

OCT 1 8 2012

	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b		
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)  9 Unknown		23d. Date of delivery Month Day Year
	Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I,		use contribute to the cause of death?  2  No 3  Probably 4  Unknown
1			24a. Was an autopsy performed?	
	25. Was case referred to medical examiner?	26. Place of Death (Check or	nly one)	
	1 Yes 2 XNo	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	5 🗙 Residence	6 Other (Specify)
	27. Manner of Death  1 😾 Natural 5 🗌 Pending 2 🗋 Accident Investigation	(Month, Day, Year) injury work?  M 1 Yes 2 No	d. Describe how inju	ury occurred
	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, te)
	(Check 2 Medical Exami	ician: To the best of my knowledge, death occurred at the time, date and place, and ner: On the basis of examination and/or investigation, in my opinion, death occurred at the re Practitioner: To the best of my knowledge, death occurred at the time, date and place,	e time, date and plac	ce, and due to the cause(s) and manner stated

29c. License number

D29193

29d. Date signed (Month, Day, Year)

10/12/2012

10

State

Registrar

24 hours after death.

Funeral Director: Aff

Stephen E. Killian, M.D., 3169 Braverton Street, Edgewater, Maryland 21037

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			Plea	ase Type o										_	ble.		
	-	For State		State	OT IVI	arylan		artmer <i>tificat</i>			and iv	lental Hy		0.0	\ I (	005	2
		Registrar  1. Decedent's Name	e (First, Middle	e, Last)			007	imout	- 0, 5	- Catin		2. Date of D		<u></u>	<del>)   (</del>	3. Time of Death	h
Physiciar Medica		Heler	n Ro	sa F	alc	cho	nski					Month Octobe		4 20	Year 12	7:45 P	M
Examine		4a. Facility Name (if Carroll I			,	h Cai	re Ctr	4b. City	Town, or		of Death inste	er	4	c. County o	of Death	oll	
Funeral		5. Social Security N	umber	6. Sex	7. Age (In vrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthpl									place (State or Fore	əign		
Director  202–16–4451  1 M 2 MF  89  Yrs. Months Days Hours Min. Month Day Year)  Usual Residence of Decedent  Win. May 12, 1923									Pen	nsylvania	1						
and show	ė	10a. State	10b. County			10c. City	y, Town or Lo	cation						_		10d. Inside City Lim	nits
Mary 28a-f otifie	irec	Maryland		arroll				_	stmi	nste:	r					1 🕅 Yes 2 □	No
th with the Maryland ms 23a or 28a-f show must be notified at		10e, Street and Nun		Marele Mare				10f. Zij	p Code	1158			10g. C	Citizen of W		ntry?	
ath wi	Completed by Funeral Director	11. Marital Status	15 St.	Mark Way	cedent E	ever in U.S	S. [13. V	Vas Dece			rigin? (Spe	ecify Yes or No	)-	U.S		can Indian,	
ter deat , or iter iminer		1 Never Marr	ied 2 🗆 Mai	Armed F	orces?		i					ecify Yes or No Rican, etc.)		Black	, White,		
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho Aedical Examiner must be notified at		3 Widowed		10ai oi i				☐ Yes			/; 			Specify:		ite	
	ᇍ		cify only high	ent's Education est grade complete		- ,			rk done d		st of work	ing	16b.	Kind of Bus	siness Ir	ndustry	
e filed within 72 hours aft tral Hygiene. ed other than "natural", event, the Medical Exan		Elementary/Sec	onday (0-12) 12	College	(1-4 or t	)+)			memal	ker				own	home		
e filed ttal Hy ed oth event	To Be	17. Father's Name (		,						18. Moth		e (First, Middle		n Surname)			
should be filed within and Mental Hygiene. is marked other tha aumatic event, the I		Michae.  19a. Informant's Na					105 14-25					ith Tre		Tours Of	ata 7in	Code	
12 sho alth an 27 is r trau		Brent Pal						Unic								D 21791	
of Hee fitem rothe		20a. Method of Disp	position	3 Removal fro	Ctoto		lace of Dispo	sition (Na	me of			Date		Location - (	_		
Page tment tant: I jury o		4 Donation			iii State		nters (	Cemet	erv		10/2	2/2012	N∈	ew Wir	ndso	r, MD	
permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic er once.		21. Signature of Fu	neral Service	irensee	D	2/		. Name a			naı	rtzler					
		23a. Part 1. Enter t	the disease, o	r complications that	caused	the death		or the mod				Winds or respiratory a		<u> 1910 - Z</u>	1//	Approximate	
Physician/		Immediate Cause ( disease or condition	(Final	only one cause on e	each line		non	110								Interval Between Onset and Death	
Medical Examiner		resulting in death)		Due to	(or as	a consequ		200									-
	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):															
ited d ansit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events  c															
ria e	_	resulting in death) Last  Due to (or as a consequence of):															
cate be e physicia s the bur	Physician/Medica	d															
eath certifics attending p	n/Mg	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, o										23d. Date	of deliv	/erv	
death le atte	sicia		No		gnant a	2 ☐ Feta t time of c		Ectopic Other (s		У				Mon	th	Day Year	
requires that the de been signed by the should be detached		9 Unknown Part IL Other signif			-	out not res	ulting in the u	nderlyina	cause div	en in Parl	f I.	23e Did	tobacco	use contril	hute to 1	he cause of death?	,
ires thi signer d be d	Completed by	Dem	eri	tis			. بر		7				_	\ /		bably 4 🗆 Unkno	
v requ	olete	Char	and i	1. 110	N		la	1	1	ä		24a. Wa				ppsy findings availal	
The lay ate has bage 2	mo:	- Con			2-6-6		1					aut per 1 🗆 Yes	opsy formed? s 2 2 1	/ de	eath?	ompletion of cause	01
cian: 'sertifica'sector,	Be	25. Was case referre	ed to medical	Hospital:		l			26. Pla	_	ath (Checi	k only one)	71				
Physical this caral direction	<u>∺</u> 10	1 Yes 2	h No	1 [ 28a. Dat			ER/Outpatier 28b. Time of		28c. Injury			ome 5 Res 28d. Describe				(y)	
ath. r: Afte	icat	1 Natural 2 Accident		igation	nth, Da	y, Year)	injury	М	work				,	,			
or Atter fter de virecto n by th	Certificate:	3 ∐ Suicide 4 ☐ Homicide	6 ☐ Could deterr	ninod 28e. Plac		ury - At ho c. (Specify	me, farm, str	et, factor	y, office			28f. Location City or To			r or Rura	i Route Number,	
	edical (	29a, Certifier 1	Certifying	g Physician: To the	best of	mv knowl	edge, death of	occured a	t the time.	date and	l place, ar	nd due to the o	cause(s) a	and manne	r as stat	ed.	_
he Ho in 24 h he Fur pleted	Med	(Check 2	Medical	Examiner: On the b	asis of e	xamination	and/or invest	tigation, in	my opinio	on, death c	occurred a	t the time, date	and plac	e, and due	to the ca	ause(s) and manner s	stated
Vith Vith Com		29b. Signature and	title of certifie	er d		1		29	c. License	number		,	29d. D	ate signed	(Month,	Day, Year)	
		her	no	den.		10,	0.0	y 7	400	25	58	45	19	0/16	10	2012	
5		30 Name and addr	ess of person	who completed ca	use of d	eath (Item	1 23a) (Type, F	rint)	TA	NA	シロラ	(8) W	N	MI	1	2178	7
Stat		31. Date filed (Mont	h, Day, Year)	2012	Registr	ar's Signat	1. pa	Mal			-		-		4	400	
Registra	r	<u> </u>	OI TO	LUIZ CA	MM	V /	. 77"										

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Samuel David Porpora Month Oct 16, 2012 **10:40** M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Columbia Howard Gilchrist Hospice of Howard County 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Jan 26, 1915 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 217-01-6746 97 MD Director 1 🛣 M 2 🗆 F Usual Residence of Decede 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director ems 23a or 28a-f sh r must be notified a **Baltimore** MD Catonsville 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 711 Maiden Choice Lane 21228 U.S.A. ural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Specify. Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Owner Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F 7 is marked o ဂ္ဂ Unkown Unkown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or Alternation Janet Dukehart daughter 10174 TracyBeth Court Ellicott City, MD 21042 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Atlantic Crematory, LLC Oct 18, 2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Se 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ CHUNIC disease or condition resulting in death) Medical Due to (o **Examiner** Sequentially list conditions, Examiner It any leading to immediat cause. (Disease or injury Divinité l'autre the Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months? Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by LOYMAN 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy 1 🗌 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ပ္ 1  $\square$  Inpatient 2  $\square$  ER/Outpatient 3  $\square$  DOA 4 Nursing Home 5 Residence funeral ( 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No filled in by the Accident Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29a. Certifier (Check only one)

29a. Certifier (Check only one)

29a. Certifier (Check only one)

3 Certifier (Check only one)

4 Description only one)

5 Description only one)

6 Description only one)

7 Description only one)

8 Description only one)

9 Description only one)

9 Description only one)

1 Description only one)

1 Description only one)

1 Description only one)

1 Description only one)

2 Description only one)

2 Description only one)

2 Description only one)

3 Description only one)

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33525 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month CT6 6002 Pearlie PHATT 1337 PM 2017 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HUSPITA Randallstonn Baltimore Northwest Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🙀 F Months Days Min. Hours Country) Director Yrs 249-46-2575 78 SC Apr 12, 1934 Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits MD **Baltimore City Baltimore** 1 X Yes 2 No 10e. Street and Numbe items 23a or ner must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 207 South Catherine Street 21223 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, 9 þ 1 Never Married 2 Married Black, White, etc. ☐ Yes 2 🗶 No Yes, Give Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify er than "natural", the Medical Exa Completed 3 X Widowed 4 Divorced Specify. Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 tal Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) LP Nurse State Hospital 12 Be 17. Father's Name (First, Middle, Last) age 1 and 2 should be filed int of Health and Mental H t: If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) ည other traumatic Joseph Nelson Lavinia Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Pyatt 2010 Greenberry Road, Baltimore, MD 21209 Baltimore, Department of He Important: If in any initial 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Oct 24, 2012 Owings Mills, Md. **Garrison Forest Veterans** 21. Sign ture Ineral Service License 22. Name and Address of Facility Estep Brothers Funeral Service. 1300 Eutaw Place Baltimore, Md 2121 Pall Enter the disease, or complications that paused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physici\_n Atherosciarotic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence oi). Examir physician and the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day the 9 Unknown signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES 1 Yes 2 No 3 Probably 4 Unknown HyperTension 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Hospital or Attending Physician: The law has autopsy page perform death? certificate 1 Yes 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 X No 1 🗌 Yes Other: ဥ 1 Inpatient 2 ER/Outpatient 3 IDOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending work' after death. 1 Yes 2 🗌 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature 29d. Date signed (Month, Day, Year) D0057634 OCTOBOR B. 2013

DHMH 17 Rev 7/2009

State Registrar Ellicott City, Maryland 21042

2095 MT. Hebron Drive

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Sig

Christine M. Braud

31. Date filed (Mo

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

'anagiotas Pas		State 1- For State Registrar	e of Maryland / Dep <i>Ce</i>	artment of ertificate of		d Mental H		eg. No. 20	12 33526
Physici Medical Exam		Panagiotas Passo Panagiotis Passo Panagiotis Passo	ast) D <b>n</b>				2. Date of Dea Month October 7		3. Time of Death 1311 hrs
		4a. Facility Name (if not institution, g 215 Deerfox Lane		4	b. City, Town, or Lutherville 7	Location of Death		4c. County of E	
Funeral Director		5. Social Security Number 6. S	Sex 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	r If Under 24Hrs	_	F	B. Birthplace (State or oreign Country Maryland
ķ		Usual Residence of Decedent  10a, State 10b, County		y, Town or Location	<u></u>		20/20/		10d. Inside City Limits
nd thow any	Ļ	Maryland Baltimo		imonium	ori				1 Yes 2 X No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 215 Deerfox Lane	e <sup>=</sup>		10f. Zip Code 21093		1	0g. Citizen of What	Country?
or items	by Funeral		1 Yes 2 X No If Yes, Give Year or Dates:	If Ye	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2 No specify:  14. Race - American Indian, White, etc.  Specify: White				
215-0036 be filed within 72 hours after mild Hygiene. **Red other than "natural" ent, the Medical Examines	Completed t	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5+) 4	during mo	ost of working life.	DO NOT use ret	ired)	Childrer Adol	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	17. Father's Name (First, Middle, Las Wayne Passon  19a. Informant's Name/Relationship		19h Mailing		Roula H	Katholos	Maiden Surname)  house, City or Town,	State Zin Code)
MD and 2 sho alth and m 27 is	<u>1</u>	Roula Katholos I	Paterakis/mothe	1.4	Lochview	. Terrace			Maryland 21093
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other tr		1 X Burial 2 Cremation 3 4 Donation 5 Other Specific	Removal from State	crematory or oth ulaney V	erplace) alley Me	em. 10,	/17/2012	? Timonium	n, Maryland
Bal permi Depar Impo		21. Signature of Funeral Service Lice	Mhi	1	050 Yor	k Road	Towsor	n, Marylar	
Physician Medical kaminer	1	23a. Part I. Enter the disease, or con failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)		Alcohol			or respiratory an	est, shock, or heart	Approximate Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence c. Due to (or as a consequence						
50, te be executed ysician and burial - transit	ledical E	X UNPENDED	d. X AMENDED #1,23a,	27,28a-f	,per me	,g934 12	2-3-12 s	m	
OX 6876 eath certifical attending ph	sician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre  1 Live birth 4 Pregnant at time of death 9 death Unknown	2 Fet	al death 3	Ectopic pregn	ancy	23d. Date of de Month	Day Year
P.O. E	by Ph	Part II. Other significant conditions	s contributing to death but not	resulting in the u	nderlying cause g	given in Part I.			te to the cause of death?  Probably 4 Unknown
of Vital Records, P.O. Box in Prysician: The law requires that the death ufter this certificate has been signed by the atternoral director, page 2 should be detached for u	Completed						24a. Was auto perfo	osy prio ormed? dea	re autopsy findings available or to completion of cause of th?  Yes 2 No
tal   cian: certifi ector,	Be (	25. Was case referred to medical examiner?	Hospital:	ED/Out-street		Other	only one)	Davidson O. J.	044
of Vital I ing Physician: After this certifi uneral director,	n: <b>T</b> o	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Yeer)	ER/Outpatient 28b. Time of Ir		ry at Work?	28d. Describe	Residence 6 🗸	Other: Scene
Division tal or Attendii rs after death. al Director: /	catio	Natural 5 Pending Accident Investiga	ation 10-7-12	fd 1:00	о Рш	Yes 2 X No	unknow		
Divi: Hospital or 24 hours after Funeral Directed filled in 1	Certification:	Suicide 6 X Could no determin			et, ractory, office t	ouliding, etc.	or Town, S	Street and Number of State) 215 Dec ville, MD.	or Rural Route Number, City erfox Ln.
Division of Vi To the Hospital or Attending Physi within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directory.	Medical		ician: To the best of my knowle ner:On the basis of examination and manner stated.						
	Ž	29b. Signature and tille of certifier	1//		29c. Licens O.C.			29d. Date signed October 8, 20	(Month, Day.Year)
8h		30. Name and address of person wh Jack Titus MD, Deput	o completed cause of death (Ite y Chief Medical Examin		Baltimore Stra	eet Baltimore	MD 21223		
	tate		32. Figistrar's Signa		I	Jot, Dakimore	, NIO 2 1 220		
Regis	strar	OPITO	UIL Chrons	p. pu	Jew -				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2012ª 2:00 Рм Peregoy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 800 222nd Street Pasadena Anne Arundel 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, OV. 1, Days Months Hours Year) 1934 219-30-9330 Director 77 Nov. 1 X M 2 □ F Yrs Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experiment provest be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zîp Code 10g. Citizen of What Country? Funeral 800 222nd Street 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married ş Baltimore, Maryland 21215-0036 1957 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed 1959 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed N/A Tile/Carpet Mechanic Be 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Peregov Mildred Triplett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances H. Peregov (Wife) 222nd Street Pasadena. Injury or other Marvland 21122 20a. Method of Disposition
1 □ Burial 2 ♣ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of I Importent: If Ite any Injury or of 4 Donation 5 Other (Specify) Atlantic Cremation 10/15/2012 Glen Burnie, Maryland 22.Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21. Signature of Funeral Service Licenses M00 - 73223a. Pa. I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of attending physician and I for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Xyes Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has a funeral director, page 2 autopsy performa 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. bescribe how injury occurred 28c. Injury at Natural 5 Pending To the Hospital or Attendin within 24 hours after death.
To the Funeral Director; Aft completely filled In by the fur 1 ☐ Yes 2 ☐ No Accident Investigation Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) m)who completed cause of death (Item 23a) (Type, Print) Silen State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October October Physician/ 16,2012 Year 6:00 A M Charles Milton Resch Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Golden Living Center of Westminster Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 88 Director 215-14-9817 1 🛛 M 2 □ F February 7,1924 Maryland John Targeren. In Mental Hygiene. In marked other than "natural", or items 23a or 28a-f shov Imatic event, <u>the Medical Examiner must be notified at</u> 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Carroll Westminster 1 A Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1239 Weller Way 21158 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 years Sales Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked Milton C. Resch Helen A. Herman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Resch Brother 1239 Weller Way, Westminster, Maryland 21158 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Crownsville VA Cem. 24, 2012 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) neumonia Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans ear that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Pregnant at time of death Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 A No 1 Yes 2 No \_\_ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) ဂ္ 1 🗌 Yes 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 10 and address of person who completed cause of death (Item 23a) (Type, Print) ACQUELIN 6880 ARN POOLE 31. Date filed (Month, Day, Year) 32. Registrar's OCT 18 2012 Registrar W DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Richard Rhone 1 Onth 201 2 13 1:00P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Emeritus Woodward Estate Bowie Prince George's Social Security Number 8. Date of Birth (Month, Day, Year) 12/28/1913 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) Funeral Days Hours 162-14-7633 Director 1**X**□ M 2 □ F 98 PA ms 23a or 28a-f show must be notified at 10h County 10c. City, Town or Location 10d. Inside City Limits Director MD Calvert Huntingtown 1 Yes X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral USA 20639 3122 Great Reward Way death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Examiner Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. and Mental Hygiene. is marked other than "natural", or i 1 Never Married 2 Married Completed by 72 hours after ☐ Yes 2 X No Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give XXWidowed 4 □ Divorced Specify: white Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pharmacy Pharmacist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cecelia Marie Hasenohr Edgar Lyle Rhone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sara R. Itschner 3122 Great Reward Way Huntingtown MD 20639 1 and 2 s f Health a item 27 i injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth once. Date Jefferson Memorial 10/19/2012 Pittsburgh, PA 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Harman Funeral Service 7221 Grayburn Dr Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or) or Attending Physician: The law requires that the death certificate be executed and the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death Day Year 2 No g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣ ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 performed' Yes 2 No 2 No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: Hssylec 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. I Director: After t 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town State) within 24 hours a To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cetying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 30. Name and on who completed cause of death\_(Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 33530 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ C. Ober Medical 0 4a. Facility Name (if not institution, give street and number)
Loch Raven Community Livin **Examiner** 4b. City, Town, or Location of Death 4c. County of Death LIVING enter Baltimore NIA If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🔀 M 2 🗆 F Month, Day, Ye. mary/and Months Hours Min Director Usual Residence of Decedent or items 23a or 28a-f show 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Baltimer Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ed Start 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black. White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: "natural", 3 Widowed 4 Divorced Specify: Completed Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene Important: If item 27 is marked other than "any injury or other traumatic excess." Elementary/Seconday (0-12) College (1-4 or 5+) Sevarit Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Lelma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Nungber, City or Town, State, Zip Code) Deborah N. Recues-Vida Balton Drive MO21207 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) GREVISON 10-24-2012 Mills 21. Signifure of Funeral Service Licensee a Low dal mo 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lipe. Approximate Interval Betwee Bladder Immediate Cause (Final oncer Letastatic Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an nas autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate be completed filled in by the funeral director, page Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No XUSPICE Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 0 11. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 Loch Ceorge E. Wicks The Raltimove Bpulev Kaven Raltimore

Registrar DHMH 17 Rev 7/2009

State

reorge

31. Date filed (Month, Day, Year)

8

and

avy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ TORER 10.36AM 15,2012 Castillo Rivera Samue 1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number If Under 7. Age (In vrs. last birthday Funeral Davs Hours Director 220-31-7672 1 💢 M 2 🗆 F Feb 15, 1939 E1Salvadore 73 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🗓 No Cockeysville Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21030 USA 529 Penny Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1∭Yes 2□No Specify: Salvadorian 1 Never Married 2 X Married Completed by If Yes, Give Year or Dates 3 Widowed 4 Divorced Hispanic 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Restaurant 06 Food Preparation n/a Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ည Rivera Lorenzo I. Castillo Jesus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10201 Greenside Drive, Cockeysville, MD 21030 Jose B. Rivera/Son-in-Law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10/17/2012 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Benation 5 ☐ Other (Specify) Timonium, Maryland Dulaney Valley Memorial Gardens Funeral Service London 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line.

Immediate Gause (Final Interval Between Onset and Death Physician/ disease or c iresulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the attending physician and the for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 9 Unknown Yes 2 ☐ No To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by t completely filled in by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 ☐ Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 10-15-12 who completed cause of death (Item 23a) (Type, Print) TOWSON, MD 21204 2. Registrar's S State

DHMH 17 Rev 06-2011

Registrar

18

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			a For	epartment of Health and I	Mental Hyg	iene	00500
			Trogress at	Certificate of Death		eg. No. 20	<u>2 33532</u>
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)		Date of Deat     Month	Day Year	3. Time of Death
-	Medic		Joyce Ann Ramirez  4a. Facility Name (if not institution, give street and number)	4b. City. Town, or Location of Death	Oct.	16 2012 4c. County of Death	3:15 P <sup>M</sup>
	Examin	ier	13404 Redcoat Lane	Phoenix	1	Baltimo	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd		8. Date of Birth	9. Birth	hplace (State or Foreign
	Director		207-30-4126 1 □ M 2 承 F 70 Yr	1 1 1	March 18		PA
	ind show at	ď	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town o	r Location			10d. Inside City Limits
	Aaryla 8a-f tified	rect	MD Baltimore Phoenix				1 ☐ Yes 2√☐ No
	a or 2	١ق	10e. Street and Number	10f. Zip Code	1	l0g. Citizen of What Cou	untry?
	h with	Funeral Director	13404 Redcoat Lane	21131		USA	
	r deat		Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
920	s after ral", o Exam	d by	1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates.	1 ☐ Yes 2 💢 No Specify:		Specify: W	hite
21215-0036	hour	Completed		ecedent's Usual Occupation live kind of work done during most of work	king	16b. Kind of Business/I	ndustry
2	hin 72 ne. <b>than</b> '	mo		e. DO NOT use retired)	Ni ig		
2	Hygie Hygie ther int, th	Be C	12 4 17. Father's Name (First, Middle, Last)	Nurse	ne (First, Middle, M	Healthcar	'e
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	70	Elvin Rummel	Helen		raderi Surilarie)	
ary	hould and M s mar			Mailing Address (Street and Number or Rui		City or Town, State, Zip	Code)
Σ	ealth an 27 in 27 in rtra			404 Redcoat Lane,	Phoenix,	MD 21131	
ore	ge 1 and it of Heal if item or other		20a. Method of Disposition  1 🔀 Burial 2 🗀 Cremation 3 🗀 Removal from State  20b. Place of Disposition cemetery,	isposition (Name of crematory or other place) 11/3/	Date 12	20c. Location - City or 1	Town, State
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot			Valley Memorial Ga		Timonium,	MD 21093
Ba	Depa Impo any i		21. Sign and W. Clary  23a. Part 1. Eyer the disease, or complications that caused the death. Do not shook of bearfailure List only one cause or each line.	22. Name and Address of Facility  Lemmon Funeral Home	e of Dula	aney Valley	, Inc.
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heardrailure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	h, si ian/		Immediate Cause (Final disease or condition	ins Lymphom	q		eight years
-	Medical Examiner		resulting in death)  Due to (or as a consequence of):	1 0			5 /
		Jer	Sequentially list conditions, b. Due to for at a consequence of:				
	nted d ansit	Examine	that in table or injury that initiated events  Lack to the accuracy of the control of the contro				
	ate be executed hysician and the burial-transit	Ĕ	resulting in death) Last  Due to (or as a consequence of):				
09	ate be hysici the bu	dical	d				
Box 687	ertifica ding ph	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			22d Date of dell	
ŏ	atten d for u	iciar		3  Ectopic pregnancy 5  Other (specify)		23d. Date of deli Month	Day Year
Э. В	the de	hys	9 ☐ Unknown				
P.0	Attending Physician: The law requires that the death certificate be executed are death.  The death.  ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transic.	by	Part II. Other significant conditions contributing to death but not resulting in t	ne underlying cause given in Part I.		pacco use contribute to	
rds	requires been sig should k	eted				es 2 No 3 Pr	
Records,	has b	Completed			24a. Was ar autops perforr	y prior to c	opsy findings available completion of cause of
E E	ician: The la certificate ha rector, page		25. Was case referred to medical	26, Place of Death (Chec	1 🗆 Yes 2		2 No
of Vital	ysician: s certific director,	To Be	examiner? 1	Other		ence 6  Other (Specia	fv)
of	tending Phyleath.  or: After thi the funeral		27. Manner of Death 1 ★ Natural 5 □ Pending (Month, Day, Year) 28b. Time inju	e of 28c. Injury at	28d. Describe ho		
ion	tendin leath. tor: Aft the fur	ifica	2 Accident Investigation	M 1 Yes 2 No			
Division	l or Atten after deat Director: d in by the	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Str City or Town	reet and Number or Run , State)	al Route Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	Medical	29a. Certifier 1 K Certifying Physician: To the best of my knowledge, de (Check 2 Medical Examiner: On the basis of examination and/or in				
	the Prithin 24	Me	only one) 3 Certifying Nurse Practitioner: To the best of my knowle	dge, death occurred at the time, date and p	lace, and due to the		s stated.
	FSFÖ		Marshell a. drive, M.D	D17873	1	October 17	
	15 V		30. Name and address of person who completed cause of death (Item 23a) (Tyr	pe, Print)			
	Sta	te	21 Date filed (Month Day Year)	9 N. Charles St.,	ouite 20	ı, Dallo.,	TID 21204
	Registra	ar	OCT 1 8 2012 Sever 1 . Agriculture 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State	tate of Maryland					9	012	33	533
			Registrar  1. Decedent's Name (First, Middle, Last)		Cer	tificate of D	eatn	2. Date of Dea		012	3. Time of D	
	Physicia Medic		1. Decedent 3 Name (1 1/3), Whate, Easty	Wayne Willia	m Rih	a		Octobe		2012	8:40	
	Examin		4a. Facility Name (if not institution, give street			4b. City, Town, or				y of Death ne Arui	ndo1	
	Funeral		212 West Riverviev  5. Social Security Number 6. Sex	al Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. B								Foreign
	Funeral Director		216 36 2864 <sub>1</sub> X M	72 TIS.       07/23/1940							Maryla	and
	nd ihow at	or	Usual Residence of Decedent  10a. State 10b. County	10c. City, 7	Town or Loc	ation		0.720	, 2, 10	10	d. Inside City	/ Limits
	Maryla 28a-f s otified	Director	Maryland Anne Arun	del Ba	1timo	re					1 Tes 2	2 <b>X</b> No
	th the		10e. Street and Number	n i		10f. Zip Code 2122	5	Ì	10g. Citizen of	What Counti	y?	
	ems 2	Funeral	212 West Rivervie	Vas Decedent Ever in U.S.	13. V	Vas Decedent of His	spanic Origin? (Sp	ecify Yes or No-	14. Ra	ce - America		
36	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	by	1 Never Married 2 Married	rmed Forces? ☐ Yes 2 <b>X</b> No Yes, Give	1	Yes, specify Cubar  Yes 2X No		Rican, etc.)		ack, White, et y: <b>Whit</b> e		
8	nours a	Completed	15. Decedent's Educati		16a. Deced	ent's Usual Occupa	ation		16b. Kind of I			
215	iin 72 h ie. han "n e Medi	dwo	(Specify only highest grade co	mpleted) College (1-4 or 5+)	life. DO	rind of work done do NOT use retired)	_	king	Corr	oet Cor	nnany	
12	ed with Hygier other t	Be C	8th  17. Father's Name (First, Middle, Last)		Car	pet Insta	18. Mother's Nar	ne (First, Middle,			прапу	
dan	ld be filed Mental Hy arked oth atic event	2		phen Riha	20			lores Fi				
Maryland 21215-0036	should nand N is ma		19a. Informant's Name/Relationship (Type, F	- 1		g Address (Street a						205
e, l	and 2 s Health tem 27		Mildred Sellers / s	20b. Plac	ce of Dispo	. Riverv		Balt Date	imore,			225
mol	Page 1 nent of ant: If i ury or o		1 ☐ Burial 2 🕱 Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	Svai iloni Gtato		natory or other place rematory	10/1	6/2012	Baltim	ore, M	lary1ar	nd
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Examiner must be notified at once.		21. Signatur Fur ral Service Licensee	noge	22	Name and Addres	s of Facility Go ie Highw	nce Fun ay Bal	eral Se timore,	rvice, Maryl	P.A. and 21	1225
23a. Part 1. Enter the disease, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition										Approximate Interval Betw On at and D		
and the same of th	Medical Examiner		resulting in death)	Due to (or as a consequer	of):	hear	1 fail	ure			15	days
	_ =	iner	Sequentially list conditions, b. = if any, leading to immediate cause. Enter Underlying	Due to (or as a consequer	no of):	a a liana	1				30	dalic
	ecutec and I-trans	Exan	Cause (Disease or injury that initiated events c. = resulting in death) Last	Due to (or as a consequer		reinon	na H	ing c				190
09/	ate be ex physician the buris	edical Examiner	d. <b>-</b>	primis	nia						300	rays
. Box 687	the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physician and mipletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?	f yes, outcome of pregnand    Live Birth 2   Fetal of    Pregnant at time of dea   Unknown	death 3	Ectopic pregnand Other (specify)	у			ate of deliver		'ear
ds, P.O.	requires that th been signed by should be detad	ed by Ph	Part II. Other significant conditions contrib	uting to death but not result	ting in the u	nderlying cause giv	ven in Part I.		topacco use con			
Division of Vital Records,	: The law recate has be	Completed by						1 Yes		were autop prior to con death? 1 Yes	npletion of ca	vailable luse of
/ital	sician certifi	To Be	25. Was case referred to medical examiner?  1 \( \sum \) Yes 2 \( \sum \) No	ital: 1 ☐ Inpatient 2 ☐ El	B/Outpatier	Othe	er: 4 Nursing F	ck only one) Home 5 Resi	idence 6 🗆 Ot	ther (Specify)		
on of \	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		27. Manner of Death  1		8b. Time of injury	28c. Injury work	y at	T	how injury occu			
Division	al or Attending P s after death. I Director: After t ed in by the funer	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location ( City or To	Street and Num wn, State)	ber or Rural i	Route Numbe	er,
_	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check 2 Medical Examiner	n: To the best of my knowled On the basis of examination a actitioner: To the best of my	and/or inves	tigation, in my opinic	on, death occurred	at the time, date	and place, and o	due to the cau	se(s) and mar	ner stated.
	To the Com		29b. Signature and title of certifier	Puneses x	n.D.	29c. License	number	9	29d. Date sign	ned (Month, E	ay, Year)	
	•		30. Name and address of person who comp Silvino B. Mune		23a) (Type, F <b>37</b>	Print) Pote	e St	Balto	nd .	2122	5	
	Cha	te	31. Date filed (Month, Day, Year) <b>QCT 1 8 2012</b>	62. Registrar's Signatur	re /							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ROSENBLUM Physician/ EPHEN OCTOBER 22:45 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 130-32-7601 1 **X** M 2 □ F Director 71 08/20/1941 New York Usual Residence of Decede 28a-f shov 10d. Inside City Limits 10a State 10c. City. Town or Location event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No Potomac Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō 23a Funeral 20854 U.S.A. 9813 Glenolden Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian ed Forces? Yes 2 \( \subseteq No 1971-Armed Forces
1 X Yes 2 If Yes, Give
Year or Dates 1 Never Married 2 X Married "natural", or þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Medical Physician should be filed within and Mental Hygiens is marked other th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Menta.
Important: If item 27 is marked any lijury or other trees. ၉ Bess Levine Philip Rosenblum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9813 Glenolden Drive, Potomac, Maryland 20854 Carol Suchman Rosenblum - Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a Method of Disposition Date cemetery, crematory or other place) 1 🔲 Burial 2 💢 Cremation 3 🗀 Removal from State Lincoln Crematory 10/18/2012 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center Signature of Funeral Service 1040 Rockville Pike, Rockville, Maryland 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ preteringso disease or condition resulting in death) Medical Due to (or as a con a quence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and I for use as the burial-transit that the death certificate be executed 11MVDHOMP Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) signed by the at 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires i within 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death?
1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a, Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 🗹 Natural 5 Pending ☐ Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 29c. License number RES-000 OCTOBER 12,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1800 ORLEANS STREET BALTIMORE MD 21287 O DNOELL State Registrar

		yl Kenneth
2-07693 SH	ent	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
INK UNK		State of Maryland / Department of Health and Mental Hygiene 1-For State  Certificate of Death  Reg. No.  20   2   3353
Physic	an/	1. Decedent's Name (First, Middle,Last)  2. Date of Death  3. Time of Death
Medical Exam	iner	DArryl Kenneth STEWART, III October 11, 2012 0300 nrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5601 Denwood Road  Baltimore
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Months   Days   Hours   Min   Foreign
Director		217-81-8341 12M 2 F 4 Yrs. World Days 110d 11 05/07/2008 Country) Md
any		Usual Residence of Decedent  10a. State
<b>A</b>	Ľ	MD BAITIMORE 1 No
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
ith the l 23a or notifie		5601 Den Wood Rd  21206  USA  11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
eath w	Funeral	1 Mever Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.
	by F	3 ☐ Widowed 4 ☐ Divorced of Pear II ☐ Yes 2 ☑ No specify: Specify: Specify: BLACK
2 hours "natur		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
036 ithin 7. ne. r than	Completed	
15-0 filed w I Hygie od othe		17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  Shade Worrell  Shade Worrell
ID 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 77 is marked other than "natural", or items 23a or 28a-f sho marke event, the Medical Examiner must be nofified at once	o Be	
MD id 2 sho lith and in 27 is		19a. Informack's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  347 E 27th St. BATIMORE, Md. 21206  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, City or Town, State)  20b. Place of Disposition (Name of cemetery, City or Town, State)  20c. Location - City or Town, State  20c. Location - City or Town, State
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygene.  tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Date 20c. Location - City of Town, State crematory or other place)
		1 MBurial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:  21. Signature of Fune all ervice Licensee  2. I ame and Addr. ss of Facility VAUGHN GREENE FUNERAL SCVS
Balt permit Depart Impor		2) augus C Jule 4905 York ROAD. BALTO, MD. 21212
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do have never the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Complete the helpful provided the p
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Smoke Inhalation and Thermal Injuries  Due to (or as a consequence of):
	Ļ	Sequentially list conditions, b
	xaminer	If any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated
cuted and transit	Į Шį	events resulting in death) Last  Due to (or as a consequence of):  d.
exe exe	Physician/Medical	UNPENDED AMENDED
760 ficate b g physi	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
Box 68760, e death certificate by the attending physiced for use as the bu	iciar	past 12 months?  4 Pregnant at time of death 5 Other (Specify)
ion of Vital Records, P.O. Box 68760, reading Physician: The law requires that the death certificate be teath.  After this certificate has been signed by the attending physic, the fluental director, page 2 should be detached for use as the burn	Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
ires that the signed by	ğ	1 Yes 2 No 3 Probably 4 Unknown
Records,  The law requir fircate has been s	Completed	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
<b>Recol</b> The law cate has lage 2 sh	E O	
ital lician: certifi rector,	Ba	25. Was case referred to medical examiner?
Of V ing Phys After this	2	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
Sion ( ttendin death. ctor: A	atior	1 Natural 5 Pending 2 ✓ Accident Investigation Oct 11, 2012 D206 hrs 1 Yes 2 ✓ No Victim of an accidental house fire
Division of Vital is a or Attending Physician is after death.  al Director: After this certiced in by the funeral director	Certification	3 Suicide 6 Could not be determined (Specific) Towns business (Pauthouses / Pauthouses (Pauthouses / Pauthouses / Pauthous
Divis Hospital or A 24 hours after Funcral Dire		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Division of Vital Rec To the Hospital or Attending Physician: The l within 24 hours after death. To the Funeral Director: After this certificate I	Medical	one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	Ž	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  O.C.M.E.  October 11, 2012
\ /	1	30. Name and actives of person who completed cause of death (Item 23a)
V	Į /	Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
S Regis	tate	AAM 4 O AA IA   // A
DHMH 17 Rev 1/		ORIGINAL
OCME 2006		

K'niyah Norra

5 Scott Plea 12-07695 UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 33536

		1- For State Certificate	of Death	Reg. No.						
Physici dical Exami		Decedent's Name (First, Middle,Last)		2. Date of Death  Month Day Year	3. Time of Death 0300 hrs					
Jaiour Exami		KNIYAH Norra Scott 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	October 11, 2012 4c. County of Death						
		5601 Denwood Road	Baltimore							
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 1 M 2 F Usual Residence of Decedent	Months Dave Hours Min	foreig						
' any		10a. State 10b. County 10c. City, Town or Lo			10d Inside City Limits					
Maryland 28a-f show d at once.	to	MD BALTIA		Lie aw	1 X Yes 2 No					
rith the Maryland 123a or 28a-f show 2 notified at once.	I Director	347 E. 27 <sup>th</sup> STREET	10f. Zip Code 21256	10g. Citizen of What Cour						
r death v	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto  Yes 2 X No specify:							
2 hours afte "natural",  Examiner	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Dece	dent's Usual Occupation (Give kind of w	vork done 16b. Kind of Business/li						
y, MD 21215-0036 and 2 should be filed within 72 hou teath and Mental Hygiene. tem 27 is marked other than "nat traumatic event, the Medical Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	g most of working life. DO NOT use retir	red) NA	1.14					
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	17. Father's Name (First, Middle, Last) Kendal Scott		(First, Middle, Maiden Surname)  Worrell  Rural Route Number, City or Town, State,						
MD 21 d 2 should th and Me n 27 is ma numatic er	2	19a. Informant's Name/Relationship (Type, Print)  Shade Worrell Motter 34	ling Address (Street and Number or R	tural Route Number, City or Town, State,	Zip Code)					
e, M 1 and 2 Health item 2		20a. Method of Disposition 20b. Place of Disposition	position (Name of cemetery, other place)	Date 20c. Location - City or	Town, State					
Baltimore, permit. Pages 1 a Department of He (important: If its njury or other t		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Qther Specify:  Dulane	y Valley 10	18/12 BALTIMON	re, Md					
Baltimo permit. Page Department o Important:		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Part I. Enter the disease, or complications that caused the death. Do not entertailly the List only one cause on each line.	Hame and Address of Facility VA	Ughn Greene Fin	erm Scvs					
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	er the mode of dying, such as cardiac or	respiratory arrest, shock, or heart	DOCTOON ON DOCUME					
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Smoke Inhalation and Thermal in Due to (or as a consequence of):	njuries		Death					
		Sequentially list conditions, b								
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated								
760, icate be executed physician and the burial - transit	I Examiner									
O, be exe sician 2	edical	UNPENDED AMENDED								
58760, srtificate b ling physic	Σ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregnal	23d. Date of delivery	ay Year					
Box 687 he death certific the attending p	Physician/	1 Yes 2 V No 9 Unknown 9 Unknown 9 Unknown	Other (Specify)							
P.O.	۵	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contribute to to 1 Yes 2 No 3 Prob						
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed			autopsy prior to c performed? death?	topsy findings available ompletion of cause of					
ul Re m: Th rtificat tor, pag		25. Was case referred to medical	26.Place of Death (Check of	1 ✓ Yes 2 No 1 ✓ Ye only one)	s 2 No					
of Vitz ing Physici After this ce uneral direc	To Be	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpati		g Home 5 Residence 6 🗹 Other	Scene					
ion of tending Pheath. tor: After to the funeral	ation:	27. Manner of Death  1 Natural 5 Pending Pown Document Pown Death Pown Death Pown Death Pown Death Pown Death Pown Death Deat		28d. Describe how injury occurred Victim of house fire						
Division  To the Hospital or Attendit within 24 hours after death.  To the Funeral Director: /	Certification	3 Suicide 6 Could not be determined (Specify) Townhouse / Rowho		28f. Location (Street and Number or Rui or Town, State) 5601 Denwood Road, Baltimore, Mi						
thin 24 ho the Fun the Fun	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.								
F B F 8	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon						
<b>7</b> ,		in his.	O.C.M.E.	October 11, 2012						
IV		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltim	ore Street, Baltimore, MD 212	223						
St Regist	ate	31. Date filed (Month, Day, Year) 2 32. Registrar's Signature								

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#18perFH, G932, 10/18/2012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar 33537 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 16 Day Physician/ oct. 20 T2 6:52A M John Henry Steinmetz Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll Hospital Center Carroll Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Year) Min 218-18-4299 90 Director 1 M 2 F 08/27/1922 MD Usual Residence of Decedent 28a-f show 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No MD Carroll Westminster 23a or 10e. Street and Number 10g. Citizen of What Country? Funeral 2214 Timothy Drive 21157 United States items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Hygiene. 1 Never Married 2 Married Completed by 1 Nes 2 No lf Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Representative Electric and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname)

Charlotte — Gerald

Charlotte 17. Father's Name (First, Middle, Last) John Francis Steinmetz permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucy Steinmetz-wife 2214 Timothy Dr., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) South Carroll Crem 10/17/12 Winfield, MD 4 Donation 5 Other (Specify) 22. Name and Address of FaciliFletcher Funeral & 21. Signatu of Nuneral Service Licensee Cremation 254 E. Main St., Westminster, MD 21157 23a Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ong estivo disease or condition Medical resulting in death) Due to (or as a co s quence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 hinknown Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page performed? death? 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 -10 ၉ 1 Tyes 1 Hepatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 Yes 2 No Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Mo 52036 2012 8× 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 21157 295 Stone CHACICO 32. Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Conrad Steindler October 16, 2012 8:40 P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Director 213-26-7008 83 Dct. 29, 1929 Maryland show 10a. State with the Maryland ir then "natural", or items 23a or 28a-f sho the Modical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Catonsville 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1204 Westerlee Place 21228 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc ۾ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 ial Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Route Driver Quest Diagnostics permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumetic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Leopold F. Steindler Marie Moshake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Steindler Wife 204 Westerlee Place: Catonsville, MD 21228 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 10/17/2012 Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee W0125 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ KESPIRATORY FAILURE SECONDARY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ASPIRATION Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or or Attending Physician: The law requires that the death certificate be executed attending physicien and for use es the buriel-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 5 Other (specify) Month Year Pregnant at time of death Day is certificate has been signed by the director, page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by GASTROINTESTINAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed? Yes 2 No death? 2 🗆 No 1 🗌 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 🗆 Nursing Home 5 🗆 Residence 6 🖾 Other (Specify) HOSPICE ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA To the Hospital or Attending Physis within 24 hours after death, To the Funerel Director: After this completely filled in by the funeral dir 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural 5 - Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 1 XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie D72139 October 17/ 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABBAS MD 6336 21044 Q CEDAR LANE MD COLUMBIA 31. Date filed (Month, Day, Year) 0CT 1 8 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 33539

		•	For State State Registrar	e or iviaryiand		tificate of L		ivicitatity	Reg. No.				
	Division	. ,	Decedent's Name (First, Middle, Last)			-		2. Date of De	ath	Voor	3. Time of Death		
	Physicia Medic	al .		helma Vir	ginia	Schaeffe	r	Octobe	er 12, 2	012	2:30 P <sup>M</sup>		
	Examin	er	4a. Facility Name (if not institution, give street and i			4b. City, Town, or	Location of Dea	ith	4c. Count				
~ **			14207 Old Gunpowder R  5. Social Security Number 6. Sex	Oad 7. Age (In yrs. las	st hirthday)	Laurel If Under 1 Year	If Under 24 Hr	s. 8. Date of Bir		ce Ge	lace (State or Foreign		
	Funeral Director		219-48-7602 1 M 2 X	F	Yrs.	Months Days	Hours Mir	n. (Month, Da	ay, Year)	Country) Virginia			
	_ M.		Usual Residence of Decedent	93				Aug 5,	1919				
	yland f shc ed at	ctor	10a. State 10b. County		Town or Loc	ation				11	0d. Inside City Limits 1 ☐ Yes 2 🏋 No		
	e Mar r 28a notifi	Director	MD Prince Georg	e Lau	rel	10f. Zip Code		T	10g. Citizen of	What Coun			
	/ith th	lal	14207 Old Gunpowder R	o a d		20707			U.S.A.	Wilat Oouii	uy:		
	ems	Funeral	11 Marital Status 12. Was D	ecedent Ever in U.S.	13. W		ispanic Origin? (	Specify Yes or No- rto Rican, etc.)	14. Rac	ce - America			
98	fter de ', or it		1 Never Married 2 Married 1 7	Forces? es 2 X No		Yes, specify Cuba		πο Rican, etc.)		Black, White, etc.  Specify:			
Ö	ours a tural	Completed by		r Dates.						wnite			
7.	72 hc in "na Medic	ldu.	(Specify only highest grade comple		(Give k	ent's Usual Occup iind of work done o O NOT use retired)		orking	16b. Kind of b	o. Kind of Business/Industry			
21215-0036	within giene. er tha , the /	S	Elementary/Secondary (0-12) College	e (1-4 or 5+)	Homem	aker			Own Ho	me			
pu	filed all Hyg		17. Father's Name (First, Middle, Last)		_			ame (First, Middle,	Maiden Surnam	e)			
yla	Ment Ment narke	The state of the s											
Maryland	2 shorth and 17 is not traun												
e,	and Healt tem 2	20a. Method of Disposition 20b. Place of Disposition (Name of Date 24)								20c. Location - City or Town, State			
mo m	age 1 ent of nt: If i		1 X Burial 2 ☐ Cremation 3 ☐ Removal for 4 ☐ Donation 5 ☐ Other (Specify)	IUIII State		natory or other place coln Cem		17, 12	   Brentw	ood,	Maryland		
Baltimore,	permit. P Departm Importal any injur		21. Signature of Funeral Se, ce Licette e	1 - 0 -									
m	o a II o		White the	M007						nd 20	707-4389		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respire shock, or heart failure. List only one cause on each line.								ac or respiratory a	rrest,		Approximate Interval Between Onset and Death		
	Physician/	7. V	Immediate Cause (Final disease or condition resulting in death)  Diabetes Type I  Due to (or as a consequence of):										
	Medical Examiner		Due	to (or as a conseque rdiovascul		20220							
		ner	Sequentially list conditions, if any, leading to immediate Due	to (or as a conseque		DC4.DC							
4	uted Id ransit	ami	Cause (Disease or injury that initiated events										
J.	icate be executed physician and is the burial-transit	edical Examiner	resulting in death) Last Due	to (or as a conseque	ence of):								
200	ate be	edic	d										
				outcome of pregnan					23d. D	ate of delive	ery		
Вох	e atter	Physician/M	in the past 12 months?	ive Birth 2  Fetal Pregnant at time of de		Ectopic pregnand Other (specify) _	СУ				Day Year		
P.O.	t the c by th	Phys	9 Unknown	Jnknown	Min or in the second	- 41-1	and in Dort I	00 5111					
σ.	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	l by	Part II. Other significant conditions contributing	to death but not resu	iting in the u	ndenying cause gi	ven in Parti.	i			e cause of death?		
rds	requir seen s	etec						24a. Was	,		osy findings available		
eco	'sician: The law r s certificate has b director, page 2 s	Completed by						- auto	opsy ormed?	prior to cor death?	mpletion of cause of		
<u>~</u>	tn: Th ifficate tor, pa		25. Was case referred to medical			26. P	ace of Death (C/		2 No	1 \( \text{Yes} \)	2 🗆 No		
Zit:	ysició is cert direct	To Be	examiner? 1  Yes 2  No Hospital:	☐ Inpatient 2 ☐ E	R/Outpatien	Oth		Home 5 KResi	idence 6 🗌 Oth	ner (Specify)			
of	ng Phys fter this ineral di			ate of injury  Month, Day, Year)	28b. Time of injury	28c. Injur work	y at </td <td>28d. Describe</td> <td>how injury occur</td> <td>red</td> <td></td>	28d. Describe	how injury occur	red			
ion	tendii Jeath. tor: Al the fu	Certificate:	2 Accident Investigation			M 1 🗆	Yes 2 □ No	-			5		
Division of Vital Records,	l or Attending I after death.  Director: After I in by the funer	Cert	4 Homicide determined 28e. Pl	lace of Injury - At hon uilding, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location ( City or To	Street and Numb wn, State)	er or Hurai	Houte Number,		
Ω	To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ical	29a. Certifier 1 X Certifying Physician: To the	he best of my knowle	edge, death o	occurred at the tim	e, date and place	e, and due to the c	ause(s) and mar	ner as state	ed.		
	he Ho in 24   he Fu ipletel	Medical	(Check 2 Medical Examiner: On the only one) 3 Certifying Nurse Practition										
	To the within 2 To the comple		29b. Signature and title of certifier			29c. Licens	e number	c	29d. Date signs	ed (Month, L	Day, Year)		
	a		Fer	Dr Gaynes C	aplen	1100	0 586	>	10/18	110			
	2		30. Name and address of person who completed of	cause of death (Item :	zda) (Type, P	Car D	Gaus	20-V	apla.	$\sim$			
	Sta	te	31. Date filed (Month, Day, Year) 3	2. Registra s Signa	ire	- IT. U			-				
	Pagietr		OCT 1 8 2012 /2		all								

			For State Registrar	State of M	larylar		artment tificate			and M	lental Hy	giene Reg. No	$2  \Omega$	12	3351	+
	Physicia	in/	Decedent's Name (First, Middle, L.		nce l	Donald					2. Date of De	ath		ear,	3. Time of Death 5:30 P.	_
	Medic Examir		4a. Facility Name (if not institution, gi	ve street and number)	ince i	Dollard	4b. City, 1	Town, or	Location o		UCTODE		County of I	Death	3.30 1.1	-
-	Funeral		1409 Patapsco  5. Social Security Number 6.	Sex 7. A	ge (In yrs. I	last birthday)	If Under	1 Year	imor	24 Hrs.	8. Date of Bir			. Birthp	ace (State or Foreig	 gn
	Director		214 50 0696 Usual Residence of Decedent	1 <b>X</b> M 2 □ F	62	Yrs.	Months	Days	Hours	Min.	017/25	7195	0	Count	Maryland	L
	ryland I-f show ied at	Director	10a. State 10b. County Maryland N/	A		ty, Town or Loo Baltimo								10	0d. Inside City Limit	
	the Ma a or 28a be notif	al Dire	10e. Street and Number				10f. Zip		_			10g. Cit	izen of Wha			_
	ath with	Funeral	1409 Patapsco	Street  12. Was Decedent	Ever in U.S	S. 13. V		2123 ent of His		in? (Spec	cify Yes or No-	. [	U.S.,		an Indian	_
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	à	1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces?		ŀ	Yes, speci	ify Cubar	n, Mexican,	, Puerto F	Rican, etc.)		Black, V Specify: W	White, e	tc.	
15-0	72 hour n "natu 1edical	Completed	15. Decedent's (Specify only highest (	grade completed)		I (Give I	kind of work	Usual Occupation f work done during most of working T use retired)					ind of Busin	ess Ind	ustry	
212	I within ygiene. her thai t, the N		Elementary/Seconday (0-12)	College (1-4 or	5+)	1	e Fig						altim	ore	City	
land	be filectental Hrked ot	To Be	17. Father's Name (First, Middle, Last Do	) onald Berna	ard S	aub1e			18. Mothe		(First, Middle, eneva H			Fitz	hugh	
Maryland 21215-0036	should the and Mand Mand Mand Mand Mand Mand Mand		19a. Informant's Name/Relationship Joann Saub1e /				•	,			Route Numbe				·	_
	of Healt of Healt fitem 2 rother		20a. Method of Disposition			1409 Place of Dispo	sition (Nam	e of	- 1		Dalu		ocation - Cit		and 21230 wn, State	_
Baltimore,	nit. Page artment ortant: I injury o		1 Burial 2 Cremation 3 4 Donation 5 Other (Special Signature of Juneral Service Lige	cify)		view C	remat	ory	1		/2012				laryland	
Ba	Depi Impo	21. Signature of Funeral Service Ligenses 22. Name and Address of Facility Gonce Fune 4001 Ritchie Highway Balt													<u>5</u>	
23a. Part 1. Enter the disease, or complications that Coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line.  Physician/ Immediate Cause (Final disease or condition as the condition of the condition in death)  a. The condition of the condition are utilized in the condition of the condition in death).								2		Approximate Interval Between Onset and Death						
	Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):	1,01									
	d sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or se	b. — Due to for de a conesquence our								13		_	
	ite be executed hysician and he burial-transit	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last	a consequ	onsequence of):								+			
09/	cate be physicia the bu	edical		d										$\perp$		_
Box 687	Hospital or Attending Physician: The law requires that the death certificate be executed 42 hours after death.  Funeral Director, After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transitied in by the funeral director, page 2 should be detached for use as the burial-transitied filled in by the funeral director, page 2 should be detached for use as the burial-transities.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 Feta	al death 3 🗆	Ectopic po Other (spe		/				23d. Date o Month		ry Day Year	
P.O.	s that the gned by se detac	by Ph	Part II. Other significant conditions					ause give	en in Part I.	l of	23e. Did t	obacco u	se contribu	te to the	e cause of death?	
ords,	requires to been sign should be	eted	CHEONIC DISS	RUCTVE		or Alo	111-7	U	200	150	1 24a, Was				ably 4 Unknov	_
of Vital Records,	The law ate has page 2 s	Completed						-			auto perfo		prio deat	r to con	pletion of cause of	
lital	sician: The la certificate ha irector, page 2	Be	25. Was case referred to medical examiner?	Hospital:	: <b>4</b> 0 🗆	ED/0-11	+ 0 C BC	Othe	ce of Deat		-					_
of \	ing Phys	ate: To	27. Manner of Death  1 Natural 5 Pending	28a. Date of inj (Month, Da	ıry	ER/Outpatien 28b. Time of injury	28	Bc. Injury work?	at	2	me 5 Resident			specity)		
Division	To the Hospital or Attending Physwithin 24 hours after death.  To the Funeral Director, After this completed filled in by the funeral di	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined  28a. Date of injury (Month, Day, Year)  M  28b. Time of injury (Month, Day, Year)  M  28c. Place of Injury - At home, farm, street, factor building, etc. (Specify)								No 2	28f. Location (\$ City or Tov			r Rural I	Route Number,	_
of the control of the									s staten	1	_					
	29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state (Check only one)  3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state (Check only one)									the causer as sta	se(s) and manner stated.	ite				
	70 Wit		29b. Signature and title of certifier	Atris	MO	)	29c.	License	number	Y		29d. Dat	e signed (M	lonth, D	ay, Year)	
			30. Name and address of person who	completed cause of	death (Item	23a) (Type, P	rint)		Q.A.	74	noli	E /	MO	7	1200	_
	Sta		31. Date filed (Month, Day, Year)	32. P/gisti	ar's Signa	ture	<u> </u>		PXTL	111	Value		ريا -		100	_
	Registra	ar	OCT 182	UIL DEMA	M	B. A.	arkal	<u> </u>								

Registrar DHMH 17 Rev 7/2009

			1 - For State Registrar	State of N	/larylan		artmer <i>tificat</i>			and M	lental Hy	giene Reg. No	2	0   2	3354
	Physici	an/	Decedent's Name (First, Middle     Name 1 days d. Days C1	•							2. Date of De		ay 20	)1 Ynjear	3. Time of Death 2:45 A. M
may	Medi Exami	cal	Myldred Dawn Sl  4a. Facility Name (if not institution				4b. City.	Town, or	Location			4c. County of Death			
	LAMIN	ilei	8100 Connectic			321	-	vy Cl						gomery	
	Funeral Director		5. Social Security Number 551-26-9387  Usual Residence of Decedent		ge (In yrs. I 93	ast birthday) Yrs.	If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Da June 2	rth ay, Year)	919	g. Birthp Count Misso	
	land f show d at	ţ	10a. State 10b. County			y, Town or Lo								10	Od. Inside City Limits
	Mary 28a-1 otifie	Director	Maryland Montg	omery	Chev	vy Chas									1 Yes 2 No
	vith the 23a or st be r	rai	10e. Street and Number 8100 Connectic	ut Avenue. /	Apt. #	#321	10f. Zip	815				_		What Count	try? of America
	leath v items er mu	Completed by Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S		Nas Dece	dent of His	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)		14. Ra	ce - America	an Indian,
36	after d I", or i xamin	d by	1 Never Married 2 Mar 3 X Widowed 4 Divorced	rried 1 Tes 2 If Yes, Give	No No		res, spec				nican, etc.)		Specif	ack, White, e y: <b>Whi</b>	
21215-0036	hours natura ical E	letec	15. Decede	nt's Education		16a. Deced	dent's Usu	al Occupa	ation			16b. k		Business/Inc	
215	iin 72 ie. ha <b>n "r</b> e Med	dwo	(Specify only higher Elementary/Secondary (0-12)	est grade completed)  College (1-4 or	5+)	life. D	kind of wo O NOT use	e retired)	uring mos	t of workir	ng				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	d with Hygier Ither t	Be C	17. Father's Name (First, Middle,			Hor	nemak	er	10 Mark	auta Niama	(First, Middle			Home	
lan	be file ental I rked o	100	Albert F. Davie	,				1			Landru		Surrian	ne)	
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address	s (Street a	nd Numbe	er or Rura	Route Number	er, City o	r Town,	State, Zip C	ode)
	and 2: Health em 27 ther tr		Charles T. Shu	tt / Son	1001			<u> </u>	len I	ane,	Potom	_	<u>`</u>		
nor	age 1 a		1 Durial 2 X Cremation			Place of Dispo emetery, cren gomery (	natory or c	ther place	e) Tno	Octo	oate Der			- City or To	wn, State ryland
Baltimore,	permit. P Departme Importar any injur		4 Donation 5 Other (		TIOH										
B	9 9 E 6		<b>&gt;</b>	N	100896	6 75	57 W	iscor	nsin	Ave.	, Bethe	esda	, Ma	rylan	ase, Inc. d 20814-350
	Physi_ian/ → Medical Examiner		23a. Part 1. Enter the disease, or shock, or hear failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Respira Due to (or as Idiopat	ne. atory saconsequ thic I	Failunuence of): Pulmona	re			cardiac o	r respiratory a	rrest,		1	Approximate Interval Between Onset and Death  Year
09/	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Funeral Director: After this certificate has freen signed by the attending physician and easily filled in by the funeral director, pare 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as									-		
. Box 6876	he death certificate y the attending phy ached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcom 1  Live Birth 4  Pregnant g  Unknown	2 Feta at time of c	al death 3	Ectopic   Other (sp		у					ate of deliver	ry Day Year
ls, P.O.	equires that the destree signed by the should be detached	ed by P	Part II. Other significant condition	ons contributing to death	but not res	ulting in the u	nderlying	cause give	en in Part	l.					e cause of death? ably 4 🗆 Unknown
Division of Vital Records,	Th law ecate has been	Completed by							_		24a. Was auto perfe 1  Yes	psy ormed?		Were autop prior to con death? 1 \(\sum \) Yes	sy findings available inpletion of cause of
tal	sician: The certificate irector, pa	Be	25. Was case referred to medical examiner?	Hospital:					ce of Dea	th <i>(Check</i>	only one)				
of Vi	Physic r this c eral dir	은 ::	1 L Yes 2 X No 27. Manner of Death	1 ☐ Inpa	1	ER/Outpatier 28b. Time of		Othe 8c. Injury	4 ∐ Nt		me 5 🔀 Resi				
o uc	nding ath. r: Afte	icate	1 Natural 5 ☐ Pendir 2 ☐ Accident Investi	ng (Month, Di		injury	M	work?		- 1	od. Describe	now injur	y occur	ieu	
Division	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	al Certificate:	3 Suicide 6 Could 4 Homicide determ	nined 28e. Place of in building, e	tc. (Specify	")					City or To	vп, State	)		Route Number,
	Hosp 24 hot Funei etely fil	Medical	(Check 2 ☐ Medical E	Prysician: To the best of kaminer: An the basis of	examination	n and/or invest	igation, in	my opinior	n, death oc	ccurred at	the time, date	and place	, and du	ue to the caus	se(s) and manner stated
	To the within To the	Σ	only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Wactitioner: To t	he best of n	ny knowledge,		urred at the License		te and pla	ce, and due to			manner as st ed (Month, D	
			•	1				0803	53	7 11		0ct	obei	r 17,	2012
			30. Name and address of person Pasquale Santi	ni, M.D., 5	5530 V	Viscons	rint) sin A			00, C	hevy C	hase	, Ma	arylan	d 20815
	Sta Registr		31. Date filed (MoMn, Day, Year)	2012 32 Regist	rar's Signat	ba	Ken								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month SULLIVAN, 2210PM ALEXANDER OCT Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE N/A OF MARYLAND MED If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 213 88 3653 **Director** 1 🛣 M 2 🗆 F Maryland 49 01/09/1963 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A Baltimore 1 x Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 1608 Cherry Street 21226 death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 be filed within 72 hours after White 1 Yes 2 X No Specify: "natural", Specify: Completed 3 Divorced Year or Dates ortant: If item 27 is marked other than "natur injury or other traumatic event, the Medical." 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Construction Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Michael Sullivan Sr. Margaret Calvert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is nany injury or Att Margaret Fox / Mother 1608 Cherry Street Baltimore, Maryland 21226 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 D Removal from State Bayview Crematory or other place) 10/13/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lios 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Promician CIRRHOSIS ALCOMOLIC disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to transed cause. Enter Underlying Cause (Disease or injury that initiated events Directo for sels-consecutions cov Exami Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Day Year Month Pregnant at time of death the g Unknown Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed this certificate Yes 2 N 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🔀 No Other: 1 🗌 Yes ျ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) n 24 hours atter useum. he Funeral Director: After the moletely filled in by the funera 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NET 194 257 6921 den Baran 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

GREENE STREET

DHMH 17 Rev 06-2011

BALTIMORE, MD

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month () CTOBER Year Napoleon **Physician** 755 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carrol RMY Westminst If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Days Min 1 0 M 2 □ F Yrs Director 212-54-6316 63 25, 1949 Maryland May Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important; if item 22 a or 28a-f show important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examinar must be redified at once. 1 ☐ Yes 2 🔀 No Director Carroll Mount Airy Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 5802 Ridge Road 21771 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XIYes 2 ☐ If Yes, Give Year or Dates: 2 No 1967-1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No White Specify: ģ 3 Widowed 4 Divorced 1969 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) State Trooper State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) T is mark Be Joseph N. Starkey Price Sarah Rebecca ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5802 Ridge Road, Mount Airy, Maryland 21771 Victoria Starkey / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State rematory Inc. 10/17/2012 | Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland Metro Crematory Inc. 10/17/2012 4 ☐ Donation 5 ☐ Other (Specify) Signature of Foreral Service Licensee Alyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death mediate Cause (Final SCU SC tastatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 2 10 No 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 1 ☐ Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 □ Yes 2 □ No investigation I Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C completely filled 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and title of certifier

State Registrar 30. Name and address of person who compl

OCT 18 2012

31. Date filed (Month, Day, Year)

no

DHMH 17 Rev 1/2001

200

ed cause of death (Item 23a) (Type, Print)

MD

5

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (Flast, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Medical 4a. Facility Name (if not institution, give treet and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore **Care** Genesis Elder If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 M 2 X F Director 118-20-6485 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director Baltimore MD NA Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5519 Summerfield Ave 21206 U.S.A. Lalbound. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces 1 Never Married 2 Married 1 Yes 2 2 XNo Completed by 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 ☐ Divorced Black Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Various Jobs 8th grade <u>Domestic</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bally Jordon George Briley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206 Simmons-Daughter-5519 Summerfield Ave. Raltimore. Helen Simu 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/16/2012 Carmel Baltimore, Md . Signatu of Funeral Service Licenses March for of wells t 4300 Wabash Ave, Baltimore, 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the move of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying as a consequence of attending physician and for use as the burial-transit Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? certificate has 1 Yes 2 No Yes To the Hospital or Attending Physician, within 24 hours after death.

To the Funeral Director: After this matter. 25. Was case referred medical funeral director, 26. Place of Death (Check-only one) Be Hospital Other 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) Ma of Death . Date of injury 28b. Time of Certificate: 28c Injury at 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗆 No (Month, Day, Year) Natural injury 5 Pending Accident Investigation completed filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🞵 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and tifle of cept 30. Name and address of person who completed cause of cheath (her) 23a) ( 111 l 31. Date filed (Month, Day State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Carey 2°012 8:10 AM Russell October Stearns Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Laurel Prince George's Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 577-22-9584 **Director** 1 🛛 M 2 🗆 F 86 March 27, 1926 Washington, D.C. Usual Residence of Decedent show 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Marvland 1 Yes 2 X No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3128 Gracefield Road, Apt. 116 20904 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 X Yes 2 ☐
If Yes, Give 2 No WWII "natural", or 1 Never Married 2 M Married Black White etc. þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced Specify. Completed White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Aircraft Draftsman Aircraft Design Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eric Swain Stearns A1ma Grace Carev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ~20878Wendy S. Cornish / Daughter 14801 Coles Chance Road, North Potomac, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite Date Montgomery Crematorium, Inc. 1 Burial 2 X Cremation 3 Removal from State October 17 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. any M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1 forter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Myocardial disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, Loding Lome Totacause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Dav Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 **X**No ျ 1 🗌 Yes 1 Inpatient 2 KER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 🗌 No Investigation Director Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Registrar DHMH 17 Rev 06-2011

State

completely

29b. Signature and title of certifig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nicholson-MD

8 20

3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

aurel Regional Hospital Emergency

1245928

7300 Van Dusen Road

Laurel,

20707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Physician/ Month 2012 Gladys M. Stockwell Medical October 0 2:08 P 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 8. Date of Birth (Month, Day, Year) October 21 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days Months Hours Director 026-18-1109 1 M 2 X F Yrs. 87 Vermont er than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Directo 10d. Inside City Limits Maryland | Montgomery 1 Yes 2 No Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10 Mateus Way 20878 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. ğ 1 ☐ Yes 2 ☒ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Completed 3 X Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Billing Clerk Hospital å 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ဍ permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic Andrew Carlson Faulkner Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Garcia / Daughter 10 Mateus Way, Gaithersburg, MD 20878 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State October 2012 23 4 ☐ Donation 5 ☐ Other (Specify) Oak Knoll Cemetery Palmer, Massachusetts 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 What An M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or injury Stroke sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending physic d for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month 5 Other (specify) Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by director, page 2 should be 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No မြ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral directors. 1 N Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 D Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D67986 October 11, 2012 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 01d Yuneng Li, Georgetown Road, Bethesda, MD 20814 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33547 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Carleton Smith Douglas АМ 2012 8:20 October 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Oak Crest Care Center Parkville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Hours (Month, Day, Year) 149-18-7766 Director 1 XM 2 - F 91 June 28. 1921 New Jersey Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location the Maryland 10d. Inside City Limits s 23a or 20a must be notified a' Director Parkville MD. Baltimore 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral USA 8830 Walther Blvd. #101 21234 and Mental Hygiene.
is marked other than "natural", or items aumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give by Black, White, etc. Page 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Plastics Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Rose Winifred Smith Howard Messenger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marsha Smith/ Daughter in Law 8810 Walther Blvd.#2015 Parkville, MD. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth once, cemetery, crematory or other place, 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify 10-18-12 Hilltop Service Co. Towson, MD. 22. Name and Address of Facility son Funeral Home, Inc. 21. Signature of uneral rvice Li 1050 York Rd. Towson, MD. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ons and Death Immediate Cause (Final Physician/ Pheumonia disease or condition Medical resulting in death) 12/20/2 **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of). Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Aprilic Stenosis Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 To the nuspector within 24 hours after death.

To the Funeral Director. After this certified to the Funeral director. To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/17/2012 R171944 - CRNP, MIN

igr V State

10/11/12@8120am

Markville

MP 21234

who completed cause of death (Item 23a) (Type, Print)

8800 Wather Blvd

ss of persor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Melissa A Schisler State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 10, 2012 Year **Medical Examiner** 1314 hrs <u>Melissa Ann Schisler</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital Rosedale **Baltimore County** 8. Date of Birth (MM/DD/YYYY 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 9. Birthplace (State or **Funeral** Foreign Country) MD Months Davs Min Hours Director 216**-**98-5289 9-16-1981 31 1 M 2 X F Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 Yes 2 X No Baltimore Co. Dundalk Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.
nut: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2063 Jasmine Road 21222 USA 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-12, Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married White, etc. Married 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical **Baltimore, MD 21215-0036** 12 N/A Real Estate Agent Real Estate 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Edward E. Schisler Judith White 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Schisler/Mother 547 N.W. Avenue D Hamlin. Texas 79520 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 1 X Burial 2 Cremation 3 Removal from State 10-15-12 4 Donation 5 Other Specify Baltimore, MD 0ak Lawn Cemetery 21. Signature of Fun rat Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA Dundalk Avenue Baltimore, MD 21222 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a Cardiac Arrhythmia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b Cardiomegaly Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last this certificate has been signed by the attending physician and I director, page 2 should be detached for use as the burial - transit The law requires that the death certificate be executed Physician/Medical X UNPENDED  $\mathbf{x}_{AMENDED}$ #1 as noted,23a-b,pt.II,27,per me,g934 12-19-12sm 23h.c.d per me g934 12-27-12 vt 23c. If yes, outcome of pregnancy Division of Vital Records, P.O. Box 68760, 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 X Fetal death Live birth 3 Ectopic pregnancy Dav Pregnant at time of death 5 Other (Specify) 8/7/2012 1 X Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 Yes 2 No 3 Probably 4 ✔ Unknown Cocaine and oxycodone use 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director; 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other: 2 ER/Outpatient 3 DOA 1 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 Yes 2 No Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 11, 2012 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Physician/ ames Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Season's Hospice Randallstown Baltimore Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Funeral Days (Month, Day, Year) Country) 216-48-2663 Director 1 XXM 2 □ F 81 MD Oct 25, 1930 Usual Residence of Decedent 28a-f show 10b. County ?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medicel Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 ☐ Yes 🏋 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6608 Parsons Avenue 21215 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ 1 ☐ Yes 2XX No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Library Maintenance 6th should be filed with and Mental Hygien is marked other ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ James A. Toulan Catherine Dougherty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Jack Toulan (Brother) 56 Town View Drive Wappinger Falls, NY injury or other 20a. Method of Disposition

A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State New Cathedral Cemetery 10/18/2012 4 Donation 5 Other (Specify) Baltimore, MD 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. Signature of Funeral Service Licens 3631 Falls Road Balto, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition neumo Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): death certificate be executed physician and sthe burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 as attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death 2 No ate has been signed by the a page 2 should be detached 1 ☐ Yes 2 ☐ Unknown a 
Unknown P.0. Part II. Oth<mark>er significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? or Attending Physician: The 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Onle Section 2 No 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manne of Death 28a. Date of injury (Month, Day, Year) thours after death. uneral Director: After the ely filled in by the funera Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours To the Funeral Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30 31. Date filed (Month, Day, Year) State 8 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#11perFH, G932, 10/22/2012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 2:00P Hilda Eleanor Uhlig 2012 Oct Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Carroll Carroll Lutheran Village Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Funeral (Month, Day, Year) Days Hours 130-14-9348 Director 1 M 2 KF 86 Germany 11-23-1925 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10c. City, Town or Location Director Westminster 1 Yes 2 No Carroll MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral St. Luke Circle, Apt. 250 21158 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ANO Specify: If Yes, Give Year or Dates Specify: white Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) 12 College (1-4 or 5+) Homemakes HOUSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Anna Prams John Drexler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Uhlig-son 910 Yarmouth Dr., Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State any injury or South Carroll Crem 10/19/12 Winfield, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lis 22. Name and Address of FacilityFletcher Funeral & Cremation St., Westminster, MD 21157 wanas Ε, Main 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only orle cause on each line. Approximate Interval Between Onset and Death Onset and Deal. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequency of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burlal-transit Due to (ol as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 1 Yes 2 No 9 Unknown ed by the a detached i 9 Unknown P.O. been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has to funeral director, page 2 is autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ within 24 hours after death,

To the Funeral Director: After this
completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best My knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 18/12 2402 se of death (Item 23a) (Type, Print) Boyde Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Elizabeth Jane Umstot 10:20 P M Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death County of Death Regional Hospita Prince George's Laurel Laure Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Min Hours Director 218-12-5416 1 M 2XXF 90 Aug.10, 1922 MD Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD College Park Prince George 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or items 23a 5022 Niagra Road 20740 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. ģ Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XX No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes ŽIŽ No Specify "natural", Completed 3X Widowed 4 Divorced Specify: White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Prince Georges and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Librarian County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown Ketzner Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health if Page 1 and 2 Gregory Knoll Umstot/ Son 5022 Niagra Road, College Park, MD 20740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō Department of Important: If it any injury or o October 24 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 2012 Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. Kein. M01053 313 Talbott Ave., Laurel, MD 20707 23a. Per 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Arteriosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner betes Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Hypertension To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760  $\ll$ Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Por in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Month Year 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 X No Other: မြ 1 X Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of s after death.

I Director: After t 28c. Injury at 28d. Describe how injury occurred Natural 5 Pendina Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a Medical t sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title D24721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurel Bowie Road. Suite 208 Laurel. Syed A. Sadig, M.D. 14333 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director name? Medical 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c, License number 29d. Date signed (Month, Day, Year) 004451 October 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Executive Park CT GERMANTOWN, MD LEE SANG-KYUNE State Registrar DHMH 17 Rev 06-2011

Nancy Fenner Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-07694 State of Maryland / Department of Health and Mental Hygiene **UNK UNK** Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Day Month Day October 11, 2012 0300 hrs WORRELL FENNER Medical Examiner NANCY 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 5601 Denwood Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min Country) MD 03/29 55 212-80-8619 Director 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State any. 1 X Yes 2 No BAUTIMORE Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examicer must be notified at once. MD 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Number USA ROAd 21206 5601 Denwood 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes BLACK Specify: 1 Yes 2 No specify: 4 Divorced If Yes, Give Year 3 Widowed viidowed 4 Univorced in 198, sine fear or Dates:
 Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ੬ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) PRIVATE DOMESTIC 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harrison Lorraine CLAYTON FENNER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 347 E. 27th ST. BALTO, MD. 21218 DAughter HARRON N. FENNER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 10/18/12 1 X Burial 2 Cremation 3 Removal from State BALTIMORE, MD Dulaney VALLEY 4 Donation 5 Other Specify VAUGHN GREENE FUNDRAL SCYS 22. Name and Address of Facility 21. Signature of Funeral Service Licens YORK ROAD. BAUTIMONE, MD. 21212 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line Death Medical a. Smoke Inhalation and Thermal Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED UNPENDED attending physician for use as the burial -The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day Month Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death 1 Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown ğ Completed 24b. Were autopsy findings available 24a. Was an this certificate has been il director, page 2 should prior to completion of cause of death? autopsy performed? ✓ Yes 2 No 1 🗸 Yes 2 No 26 Place of Death (Check only one) 25. Was case referred to medical Be Other Nursing Home 5 Residence 6 Other: Scene examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury After 1 27. Manner of Death Victim of house fire Certification: FOUND 1 Yes 2 ✔ No 1 Natural Pending Oct 11, 2012 0206 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 5601 Denwood Road, Baltimore, MD 3 Suicide Could not be

Hospital or Attending Physiciao: 24 hours after death filled in by the f within 24 hours after To the Funeral Direct

> Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 3. Registrar's Signature 31. Date filed (Month, Day, Year) OCT 1 8 2012

30. Name and address of person who completed cause of death (Item 23a)

determined

4 Homicide

29a. Certifier 1

29b. Signature and title of certifier



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

(Specify) Single Family Home

and manner stated

October 11, 2012

29d. Date signed (Month, Day, Year)

State Registrar

			For State	State of Ma	aryland / [	Depar	tment	of H	lealth a		_		_		33551	
			Registrar  1. Decedent's Name (First, Middle, Las	at)	<del>-</del>	Certi	ificate	of D	eatn	- 1	2. Date of Dea	Reg. No	0.		3. Time of Death	
	Physicia		Ronald Josep	•							OCT.	19	<sup>py</sup> 20	0 <sup>Y</sup> fa2	1:35A M	
	Medic Examin		4a. Facility Name (if not institution, give	street and number)		T			Location o			40	c. County	of Death		
			Carroll Hospic						nste				Car			
	Funeral Director		5. Social Security Number 218-32-5944  Usual Residence of Decedent	ex 7. Age	76		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da) 4-11-	y, Year)	6	9. Birthp Count MD	lace (State or Forei <b>gn</b> ry)	
	/aryland 8a-f shov tified at	rector	MD 10b. County Carro.	11	10c. City, Town	or Loca		estr	mins	ter			10d. Inside City Lin			
	with the h s 23a or 2 ust be no	Funeral Director	10e. Street and Number 53 Webster St	•			10f. Zip		2115	7		10g. C	itizen of V USA	Vhat Coun	try?	
9036	permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show with juury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☐ I If Yes, Give Year or Dates.		1			spanic One n, Mexican Specify:		cify Yes or No- Rican, etc.)		Blac	e - America k, White, e white	tc.	
Baltimore, Maryland 21215-0036	rithin 72 hou lene. r than "natu the Medica	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4 or 5		(Give kin life. DO l	nt's Usual nd of work NOT use	done di retired)	ntion uring most	t of workin	g		6b. Kind of Business/Industry Military			
yland 2	I be filed wil fental Hygie rked other tic event, th	To Be	17. Father's Name (First, Middle, Last) Dale E. Weave	r	<b>L</b>			18. Mother's Name (First, Middle, Maiden Sumame) Laura M. Mitten								
, Mar	nd 2 shoulealth and m 27 is m		19a. Informant's Name/Relationship (7) Nancy Lou Weave								Route Number					
imore	Page 1 endemont of Helpant: If itel		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specification 1)		20b. Place of cemeter	y, crema: grea	tory or oti en M	her place em	1	0-20	<sup>ate</sup> -2012	Fi	nksk		, MD	
Ball	21. Signiture of Funeral Service Licenser  22. Name a 254 I							. Ma	ain S	st.,	Westm:	ins	nera ter,	l & MD 2	Cremation 21157	
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or composition, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line	the death. Do not be seen to be s		the mode	of dying	, such as	cardiac o	respiratory an	rest,		8	Approximate Interval Between Onset and Death	
	be e sicier	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infittated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):														
Records, P.O. Box 6876	To the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after death.  Of the Funerial Director: After this certificate hes been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	1 Live Birth	3c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)				23d. Date of Month				ry Day Year			
ls, P.O	requires that the der been signed by the s should be detached	þ	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in	n the unc	derlying ca	ause give	en in Part 1	l. 					e cause of death?	
Record	sicien: The law req s certificate hes bee lirector, page 2 sho	Completed											1 5	Were autoporior to conteath?	sy findings available inpletion of cause of	
<u> </u>	ysicien: T is certifica I director, p	Be	25. Was case referred to medical examiner?	Llauriast.				_	ce of Deat	th (Check	only one)					
Ξ	Physic this or	우	1 ☐ Yes 2 ☐ Ho  27. Manner of Death	Hospital:  1  Inpatie  28a. Date of injur	nt 2 ER/Ou y 28b. T	<del></del>			4 ⊔ Nu						Dors Hein	
0 _	ding Ph th. After th funeral	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,		ijury	м 28	lc. Injury work?	at Yes 2□		8d. Describe h	iow inju	ry occurre	ea		
Division of Vital	To the Hospital or Attendii within 24 hours after death. To the Funerel Director: Al completely filled in by the fu	Certificate:	3 Suicide 6 Could not be determined			m, street	t, factory,	office		2	8f. Location (Street and Number or Rural Route Number, City or Town, State)					
<del>-</del>	he Hospit iin 24 hour he Funere ipletely fille	Medical	(Check 2 Medical Exam	sician: To the best of r iner: On the basis of ex se Practitioner: To the	amination and/or	investiga	ation, in m	y opinior	n, death oc	curred at	the time, date a	nd place	e, and due	to the cau	se(s) and manner stated	
	Vith Con		29b. Signature and title of certifier	un		29c. License number 29d. Date signed (Month, Day, Ye						lay, Year)				
-	STIV		Robert Kice,	completed cause of de	eath (Item 23a) (T	Sul-	te 1	7, V	Nestr	nine	ta, N	D	2115	7		
	Stat Registra		31. Date filed (Month, Day, Year)	112 32. Fegistra	's Signature	An	ele)	•								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 215 Jacqueline Wright Medical 2012 4a. Facility, Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death mor N/A Social Security Nurficer If Under 1 Yea **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign (Month, Day, Year) Months Hours Min. Director 219-22-6057 1 □ M 2 K F 84 Yrs. 10/03/1928 NC Usual Residence of Decedent or 28a-f shov 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD 1 Yes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 413 South Bentalou Street 21223 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 ☐ Yes 2 🗓 No 1 ☐ Yes 2 🛣 No Specify: If Yes, Give 3 A Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Factory Worker Plastics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ John Hollie Marv Reece . Page 1 and 2 shou tment of Health and tant: If item 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. Wright, Daughter 163 Main St. Emmaus, PA 18049 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Important: If its 20c. Location - City or Town, State 1 🗵 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 10/18/2012 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. 5305 Harford Road. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) DEU MONIG 1eek Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records/P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Month Dav Year ed by the a 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 perform 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 218 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No. Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

345

32. Registrar's Signatu

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #8.per INF, 2935 1-18-13 sm
State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Larry R. Williams Medical Oct.8, 2012 1305 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Towson Baltimore . Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Days Months Min. Hours (Month, Day, Ye Country) Director 212-60-9631 1 M 2 D F Jan 21, <del>195</del>7 Yrs MD Usual Residence of Decedent show I Hygiene. other than "natural", or items 23a or 28a-f shov vent, the Macinst Examinan or must be notified at 10a, State with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD **Baltimore** 1 Yes 2 No **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2131 St. Lukes Lane 21207 within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. \$ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 2 No 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Specify: Black Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Odd Jobs Self Employed Be parmit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 ia marked othany Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John T. Williams Della Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev. Zollie Bagby 2131 St. Lukes Lane, Baltimore, MD 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. Oct 10, 2012 Catonsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P 1300 Futaw Place Baltimore, Md 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart vailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prysician/ Medical disease or condition resulting in death) metast-or CON Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): After this certificate has been signed by the attanding physician and funeral director, page 2 should be detached for usa as tha burlal-transit Hospital or Attending Physician: The law raquires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Day Pregnant at time of death Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) မြ 1 🗌 Yes 2×2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA s after death.
I Director: After this od in by the funeral d 4 Nursing Home 5 Residence 6 Other (Specify) NOS() (C Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State To the Hospital or within 24 hours aft To the Funeral Di completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and title of certifie 29b. Sic 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) auson M 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 15, 2012 2:50 Рм Eliner M. Wolf Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Timonium Baltimore Stella Maris Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Hours Min. (Month, Day, Year) **Director** 218-28-7093 1 🗆 M 2 🗓 F Yrs. Sept. 22, 1931 81 Maryland ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits **Funeral Director** 1 Yes 2 No Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10535 York Road 21030 USA ıra", or item Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Completed by Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: 3 ☑ Widowed 4 ☐ Divorced Specify: white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) permit. Page 1 and 2 should -e filed within Department of Health and Mental Hygiene. Important: If item 27 is mar ed other thai any injury or other traumati: event, the Nay injury or other traumati: College (1-4 or 5+) 12 Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ George Durkin Margaret Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur G. Wolf 14 English Saddle Court; Parkton, MD 21120 son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Other (Specify) Gardens of Faith 10/18/2012 Overlea, MD 22. Name and Address of Facility 1050 York Road MD 21204 Ruck Towson Funeral Home, INc. Towson. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CEREBROVASCULAR ACCIDENT disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗆 No I ☐ Yes 2 X No 1 Tes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes Certificate: To 2 😿 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 2012 rson who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. **CRNP** JACKIE JONES, TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State Registrar

OCTOBER 15,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33558 = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Harold John Wendt 12:20 pm September 30,2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Medstar Montgomery Medical Center Olney Montgomery Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours **Director** 312-14-7877 1 🗶 M 2 🗆 F 90 May 31, 1922 Indiana Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Maryland 1 Yes 2 X No Silver Spring Montgomery 10f. Zip Code d 10g. Citizen of What Country? Funeral 23a U.S.A. 501 Piping Rock Drive 20905 items ; death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? 1 X Yes 2 □ No Korean 0 Black, White, etc. þ 1 Never Married 2 X Married 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify "natural", 3 Widowed 4 Divorced Completed E WWII White Year or Dates event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working Decedent's Education 16h Kind of Business/Industry (Specify only highest grade completed) than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government Musician marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Wendt Emma Lena Cook other traumatic should I and Me 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Marie Wendt - Spouse 501 Piping Rock Drive, Silver Spring, Maryland 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Crematory: 10/12/2012 | Brentwood, Maryland Signature of Funeral Service L 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease or complications that are ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that the death certificate be executed that initiated events resulting in death) Last buria!physician the burial Physician/Medical P.O. Box 68760 IF FEMALE: JSe 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy fo in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death ed by the a Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Division of Vital Records, 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? cate has the page 2 s 24a Was an perform certificate 2 🗌 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 17 No Be 26. Place of Death (Check only one) Other: 2 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director, After this completely filled in by the funeral of 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending 2 Accident 1 Yes 2 \ No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar 1 8 2012

Certifying Nurse

29d. Date signed (Month, Day, Year,

WO 18109 Prince Philip Dr., Olney, MD 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Yosuico 6:00 October AMMedical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10001 Windstream Columbia Howard Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Hours Director 212-40-1935 84 1 ▼ M 2 □ F Nov. 19,1927 Philippines Usual Residence of Deceder permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at ones. 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland | Howard Columbia 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10001 Windstream Drive 21044 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married Black, White, etc. Completed by Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. 3 ¥ Widowed 4 ☐ Divorced Specify: Asian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Physician Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Felipe Yosuico Bartola Mercado 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew Love / Son-In-Law 10222 Centennial Woods Ln., Ellicott City,MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc. 10/18/2012 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Suneral Service Licensee ALYSON K Taylor | 22. Name and Address of Facility CREM KIORY 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ Morany disease or condition resulting in death) Medical Due to (or as a confequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has been signompletely filled in by the funeral director, page 2 should I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 # Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes Investigation 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 1 MC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 110 0-18151 Oct 16 2012 0, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 St. Chi-Shiang Chen, Paul Place, Suite 409, Baltimore, Maryland 21202

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year) 0CT 1 8 2012

32. Registra s Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Gerard J. Zeller, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 221 Hunters Ridge Road <u>Tim</u>onium If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Hours Min (Month, Day, Year) 215-03-4146 Director 1 X M 2 □ F 93 9. 1919 Maryland 10c. City, Town or Location 10d. Inside City Limits 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10b. County Director 1 🗌 Yes 2 😾 No MD Baltimore Timonium 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21093 **USA** 221 Hunters Ridge Road 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Completed 3 Nidowed 4 □ Divorced white Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gerard M. Zeller Helen Connelly t. Page 1 and 2 should by rtment of Health and Mer rtant: If item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rainflower Path #304; Sparks, MD 21152 Gerard J. Zeller, Jr. permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖎 Aremation 3 Removal from State Hilltop Service Corp 10/22/2012 Towson, MD Other (Specify) 4 Donation Signature of Fund eral Service Liberis 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, MD 21204 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) attending physician end for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ TENDSIS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work?
1 ☐ Yes 2 🗆 No 2 Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number.

Baltimore, Maryland 21215-0036 or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours after death.

Funeral Director: After this certifical letely filled in by the funeral director, Certificate: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day,

M.D. 10 GERARD

State Registrar 31. Date filed (Month\_Day

aci i tobolit i		State of Maryland / Department of Health and Mental I  1-For State  Certificate of Death	Hygiene	201	2 225			
Dhysisi		Registrar Certificate of Death	2. Date of Deat	eg. No.	2 3 3 5 3. Time of Death			
Physici ical Exami			Month Septembe		1723 hrs			
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Dea		4c. County of Death Frederick				
E		6102 Amys Terrace Mount Airy  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H	Hrs 8 Date of Birt	th(MM/DD/YYYY) 9. Birth	holace (State or			
Funeral Director			din	Foreig	n Californi untry)			
ku w		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limit			
	ō	Maryland Frederick Mt. Airy			1 Yes 2X N			
ne Maryland or 28a-f show fled at once.	Director	10e. Street and Number 10f. Zip Code 6102 Amys Terrace 21771	10	og. Citizen of What Cour	ntry?			
DAILLINGTE, MID X 1 X 19-70U30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral [			14. Race - Ameri White, etc.	can Indian, Black,			
fter de	y Fu	3 G VAIDOWED 4 DIVOICED IN 188, SHE 188		Specify:	white			
ours a	d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re-		16b. Kind of Business/I	ndustry			
in 72 h	Completed	Elementary/Secondary (0-12)  College (1-4 or 5+)  5+  Optometrist	emouj	Optometr	У			
L L I 3-0030 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Сош		me (First, Middle, M	l Maiden Surname)				
l be fill ental F urked vent, 1	Be	Robert Arterburn Lois Hammaker						
27 is martic e	To	19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number of Douglas Arterburn - son   6102 Amys Terrace, M			, Zip Code) 21771			
Dermit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or				
Page:		Stauffer Crematory 10	<b>-2-</b> 2012	Frederick,	•			
1 6 g t t		21. Signature of Funeral Service Licensee 22. Name and Address of Facility S						
Line ber								
	.5	Aharow Ganule Gline 1621 Opossumtown  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	Pike, Fr	ederick, Ma	ryland 2. Approximate Interv			
Physician Medical	.9	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	Pike, Fr	ederick, Ma	ryland 2. Approximate Interv			
Physician Medical	.5	Sharrow Camule Cline 1621 Opossumtown 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	Pike, Fr	ederick, Ma	ry1and 2.  Approximate Interv Between Onset an			
Physician Medical	er ,	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Contact Gunshot Wound of Head  Due to (or as a consequence of):  Sequentially list conditions,	Pike, Fr	ederick, Ma	ry1and 2.  Approximate Interv Between Onset an			
Physician	miner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Couse. Enter Underlying Cause (Disease or injury that initiated)  Due to (or as a consequence of):  Due to (or as a consequence of):  c	Pike, Fr	ederick, Ma	ry1and 2.  Approximate Interv Between Onset an			
Physician Medical Examiner	Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Last Contact Gunshot Wound of Head  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Pike, Fr	ederick, Ma	ry1and 2.  Approximate Interv Between Onset ar			
Physician Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause.  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  C	Pike, Fr	ederick, Ma	ry1and 2.  Approximate Interv Between Onset an			
Physician Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate couse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE:  1621 Opossumtown	Pike, Fr	ederick, Ma	ry1and 2. Approximate Interview Between Onset an Death			
Physician Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  d.  UNPENDED  AMENDED  23c. If yes, outcome of pregnancy 1 Live birth 2 Ferguson at thims of death 3 Ectopic pregnancy 1 Live birth 2 Ferguson at thims of death 3 Ectopic pregnancy	Pike, Fr	ederick, Ma est, shock, or heart	ry1and 2. Approximate Interview Between Onset an Death			
Physician Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Chiese Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	Pike, Fr	ederick, Ma est, shock, or heart	ry1and 2. Approximate Interview Between Onset an Death			
Physician Medical Examiner	Physician/Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Live birth  Date to (or as a consequence of):  Due to (or as a consequence of):	Pike, Frecor respiratory arrespiratory arres	ederick, Ma est, shock, or heart  23d. Date of delivery Month D bacco use contribute to	Approximate Intervigence Onset an Death  Pay Year  The cause of death?			
Physician Medical Examiner	Physician/Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  d.  UNPENDED  AMENDED  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) 9 Unknown	Pike, Frecor respiratory arrespiratory arres	ederick, Ma est, shock, or heart  23d. Date of delivery Month Deacco use contribute to	Approximate Intervibet Between Onset an Death  Pay Year  The cause of death?  The cause of death?			
Physician Medical Examiner	Physician/Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  d.  UNPENDED  AMENDED  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) 9 Unknown	pike, Frecor respiratory arrespiratory arres	23d. Date of delivery Month  2 No 3 Prob sy prior to c death?	Approximate Intervibetween Onset an Death  Pay Year  The cause of death?			
Physician Medical Examiner	Physician/Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.  Due to (or as a consequence of):  Due to (or as a consequence of):  d.  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Live birth  Pregnant at time of death  Due to (or as a consequence of):  Due to (or as a	gnancy  23e. Did to 1 Yes  24a. Was a autops perfor 1 Yes 2	23d. Date of delivery Month  2 No 3 Prob par 24b. Were au prior to co	Approximate Intervibetween Onset an Death  Pay Year  The cause of death?			
Physician Medical Examiner	Be Completed by Physician/Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or	panancy  23e. Did to  1 Yes  24a. Was a  autops perfor  1 Yes 2  2k only one)	23d. Date of delivery Month  2 No 3 Prob sy prior to c death?	Approximate Intervibetween Onset an Death  Pay Year  The cause of death?			
Physician Medical Examiner	To Be Completed by Physician/Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence o	panancy  23e. Did to  1 Yes  24a. Was a autop perfor  1 Yes 2  2k only one)  sing Home 5 1	23d. Date of delivery Month  bacco use contribute to 2 No 3 Prob  an sy med? 2 No 1 Ye  Residence 6 Other  Owninjury occurred	Approximate Interv. Between Onset an Death  Pay Year  The cause of death?			
Ing Physician: The law requires that the death certificate be executed  After this certificate has been signed by the attending physician and  Inneral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate couse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence	prike, Free correspiratory arrespiratory arr	23d. Date of delivery Month  bacco use contribute to 2 No 3 Prob in 24b. Were au prior to c death? 1 Ye  Residence 6 Other tow injury occurred	Approximate Intervibetween Onset an Death  Pay Year  The cause of death?			
Ing Physician: The law requires that the death certificate be executed  After this certificate has been signed by the attending physician and  Inneral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate couse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence	prike, Free correspiratory arrespiratory arr	23d. Date of delivery Month  2 No 3 Prob prior to c death? 1 Ye  Residence 6 Other low injury occurred self	Approximate Intervibetween Onset an Death  Pay Year  The cause of death?  The cause of death?			
Ing Physician: The law requires that the death certificate be executed  After this certificate has been signed by the attending physician and  The physician and the detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Constituting in death)  Due to (or as a consequence of):  Due t	23e. Did to 1 Yes 24a. Was a autopo perfor 1 Yes 2 2k only one 28f. Describe hot Subject shot 28f. Location (S or Town, Si 6102 Amys Te	23d. Date of delivery Month  bacco use contribute to 2 No 3 Prob an sy Month  24b. Were au prior to c death? 1 Ye  Residence 6 Other ow injury occurred self  street and Number or Ru iate) arrace, Mount Airy, MI	Approximate Intervibetween Onset an Death  Pay Year  The cause of death?  The cause of death?			
Ing Physician: The law requires that the death certificate be executed  After this certificate has been signed by the attending physician and  functral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Couse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence o	Pike, Free correspiratory arrespiratory arr	23d. Date of delivery Month  bacco use contribute to 2 No 3 Prob an sy med? 2 No 1 Ye  Residence 6 V Other low injury occurred self  itreet and Number or Ru tate) itrace, Mount Airy, MI e(s) and manner as state	Approximate Interv. Between Onset an Death  Pay Year  The cause of death?  The cause of death			
tending Physician: The law requires that the death certificate be executed at the law requires that the death certificate be executed and or. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Imperiphy Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of	Pike, Free correspiratory arrespiratory arr	23d. Date of delivery Month  bacco use contribute to 2 No 3 Prob an sy med? 2 No 1 Ye  Residence 6 V Other low injury occurred self  itreet and Number or Ru tate) itrace, Mount Airy, MI e(s) and manner as state	Approximate Intervibetween Onset an Death  Pay Year  The cause of death?  The cause of death?			

DHMH 17 Rev 1/2001 OCME 2006

Registrar

31. Date filed (Month, Day, Year) 2012

ORIGINAL

32. Registrar's Signature

OGME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician/ Month HELEN E. BERRY September 27 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital at Easton Memorial Easton Talbot If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Social Security Number 7. Age (In vrs. last birthday) Days Months Hours Min. (Month, Day, Year) Country 487-26-7512 87 Director 1 □ M 2 🗓 F 12/31/1924 MICHIGAN Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10c. City, Town or Location Director MD TALBOT EASTON 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21601 9002 GOLDSBOROUGH NECK ROAD USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EVA MARGARET RIEBOLD IRVIN C. STAEUBLE Berry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 423 SOUTH 2ND STREET, DENTON, MD CANDACE C. MINNER, FRIEND Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Donation 5 Other (Specify) WOODLAWN MEMORIAL PK 10/3/2012 EASTON, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
200 SOUTH HARRISON STREET, EASTON, MD 21601 21. Signature of Funeral Service Licensee MERCERON JOHN R 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBROVASCULAR ACCIDENT Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ATHEROSCIEROSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig ; page 2 should b 2 ☑No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 After this certificate has Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) |₽ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral is 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) sheet solus 00059487 09-28-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219 SOUTH WASHINGTON STREET, EASTON, MD RSIO JOHN BOTSIS, MD

DHMH 17 Rev 06-2011

State Registrar 32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BURGESS SEPTEMBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ELEN BURNIE ANN ARUNDEI BALTIMORE-WASHINGTON MEDICAL CENTE 5. Social Security Number If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 03/05/1963 219-78-2967 Director 1 🗆 M 2 🚨 F Maryland 49 Usual Residence of Decedent or than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 No Anne Arundel Pasadena Maryland| 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States Funeral 21122 242 Beachwood Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo ፩ Maryland 21215-0036 1 Yes 2 No Specify: White If Yes. Give 3 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H Elizabeth L. McNulty Edward P. Gallagher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 soft Health a item 27 i 242 Beachwood Road, Pasadena, Maryland 21122 Donald F. Burgess/Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1X Burial 2 Cremation 3 Removal from State West River, Maryland Our Lady of Sorrows Cem. 09/29/2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Europeal Service Vicenses 22 Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final Physician/ 2Ebtic disease or condition resulting in death) 2440 Medical Due to (or as a consequence of) Examiner 2 DAU 5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami the attending physician and thed for use as the burial-transit Cause (Disease or Injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death page 2 should be detached g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 🔀 No certificate 1 ☐ Yes 2 🔼 No erai Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral Completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Guilarmo José Guinggoco, MD 11823000 とをしんたいわもど ブップンラン 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 HOSPITAL DRIVE, GIEN BURNIE, MD 20161-5803 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 24 Physician/ Clem Beckles 7:51A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctor's Hospital Lanham Prince George's 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 578-76-3155 Director 1 X M 2 □ F 67 Nov.9,1944 Trinidad, W.I. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland **Funeral Director** Prince George's Lanham 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20706 USA 7504 Newburg Dr. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ρ 21215-0036 within 72 hours after 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiens I Important: If item 27 is marked other than any injury or other traumatic event, the Meonce. College (1-4 or 5+) Elementary/Secondary (0-12) Engineer Howard University Be Maryland filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Darrell Beckles Page 1 and 2 should be 1 nent of Health and Menta Evelyn Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn Beckles /Wife 7504 Newburg Dr., Lanham, MD 20706 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Gate of Heaven Cem. Oct.1,2012 | Silver Spring,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature f Juneral Service 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, at 1. Enter the disease or complications that caused hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final monary Ph\_si\_ian disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 욘 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient within 24 hours after death.

To the Funeral Director, After this completely filled in by the funeral di Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29d. Date signed (Month, Day, Year) 9125 tour s son

DHMH 17 Rev 06-2011

2

State Registrar LANhon, Md 20706

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				iaryland / Dep				7111	2 33565					
			State RegistrarAmend #26 Per FH  1. Decedent's Name (First, Middle, Last)	JM 10/3/9	Edito of D	Catri	2. Date of Dea	Reg. No.	3. Time of Death					
	Physicia Medic		Evelyn	Ве	11		100gh	Day 7 Year						
	Examin	er	4a. Facility Name (if not institution, give street and number)  Heritage Care		4b. City, Town, or Silver	Spring		4c. County of Dea						
	Funeral	0	5. Social Security Number 6. Sex 7. Ac	ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Bi	rthplace (State or Foreign					
	Director		138 16 8710	98 Yrs.	Worlding	, louie	04 <sup>Month</sup> , 27	-1914	NJ					
	land show d at	tor	10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits					
	e Mary r 28a-1 notifie	Sirec	MD Montgomery  10e. Street and Number	Silve	r Spring			10a. Citizen of What C	1 Ves 2 No					
	death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral Director	9515 Lawnsberry Terr		20901			USA						
	death items		11. Marital Status 12. Was Decedent	Ever in U.S. 13.	. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi						
20	within 72 hours after gjene. ier than "natural", or the Medical Exami	ed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates.	No	1 Yes 2 No	Specify:		Specify: B	lack					
2-003p	2 hour "natur edical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupa kind of work done d	ation uring most of work	ing	16b. Kind of Business	Industry					
171	ithin 7 iene. r than the Me	Com	Elementary/Seconday (0-12) College (1-4 or 2	5+)	omemaker			Private						
שמ	2 should be filed within 72 hours after death with the Maryland h and Mental Hygene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	o Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam		Maiden Surname)						
ryland	ould be d Ment marke matic	ပ္	James Stewart  19a. Informant's Name/Relationship (Type, Print)	10h Mai	ling Addrage (Street a		Easley	; City or Town, State, Z	in Code)					
	d 2 sho alth an 27 is er trau		Gail B. Jackson daughter	8318	Chapel La	ake Ct A	nnandal	e VA 2200	3					
saltimore,	permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stat	20b. Place of Disp cemetery, cre	position (Name of ematory or other place	e) [	Date	20c. Location - City of	·					
	nit. Pag artmen ortant: injury e.	1	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee 4 € €		Cemetery 22. Name and Addres			<u>Montclair</u> neral Home						
Ra	permit Depar Impor any in	1	reh & Druf		314 Frankl	in St A	Lexandri	a, VA 2231						
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final											
	Medical		disease or condition	s a consequence of):										
	Examiner	<u>_</u>	Sequentially list conditions	diopulm	onary 1	trest			5-6 minutes					
_	ed	Examiner	if any, leading to immediate  cause. Erner Underlying  Cause (Disease or iinjury	s a consequence of):	to Thr			4 month 5						
	cate be executed physician and the burial-transit	Exa	that initiated events c. Due to (or as			5-6 minutes 4 month 5 > 5 years								
09	ate be physici the bu	edical	d	zheimer	s Der	ren la			15 years					
29	certific inding l use as	II/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcom		☐ Ectopic pregnanc	v		23d. Date of d	•					
Rox	e death the atte	Physician/M		at time of death 5	Other (specify)	,		Month	Day Year					
P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours at er death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Ph	Part II. Other significant conditions contributing to death	but not resulting in the	e underlying cause giv	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?					
ds,	equires een sigi	ted t	It yper tension						Probably 4 Unknown					
Division of Vital Records,	law re has be ge 2 sh	Completed	Cured Breast	Cancel	r - 198	G	24a. Was autor perfo	prior to	autopsy findings available completion of cause of					
E E	sician: The law r certificate has t lirector, page 2 s	Be Co	DCPCLSION 25. Was case referred to medical		26. Pl	ace of Death (Chec	1 🗌 Yes ck only one)	2 XijNol 1 ⊔ Y	es 2 No					
Z K	hystolan: this certific al director,	မ	examiner? 1 Yes 2 No Hospital: 1 Inpa  27. Manner of Death 28a. Date of in	atient 2 ER/Outpati				Rehabacen	ter					
0 1	ding F th. After funer	cate	1 Natural 5 Pending 2 Accident Investigation		/ work		28d. Describe i	now injury occurred						
isio	er dea rector by the	Certificate:	3 Suicide 6 Could not be 28e. Place of I	njury - At home, farm, setc. (Specify)	street, factory, office		28f. Location (S City or Tow	Street and Number or F vn, State)	lural Route Number,					
۵	To the Hospital or Attending Phys within 24 hours af er death.  To the Funeral Director After this completed filled in by the funeral di		29a. Certifier 1 Certifying Physician: To the best	of my knowledge, deat	h occured at the time	, date and place, a	and due to the ca	use(s) and manner as s	stated.					
	To the Hos within 24 h To the Fur completed	Medical	Obesis O Madical Evaminari On the basis of	Eavamination and/or invi	estigation in my oninio	on death occurred :	at the time, date a	and place, and due to the	e cause(s) and manner stated.					
_	Viit To To Con		29b. Signature and title of perifficit	10	29c. License	3 d (2.5	4	29d. Date signed (Mor	8/2013					
	12		30. Name and address of person who completed cause of	death (Item 23a) (Type	e, Print)	× >	00.	1 113	- 1 - 1 - 1					
			only one) 3 Certifying Nurse Practioner: To the 29b. Signature and title of certifier  30. Name and address of person who completed cause of the 20b of th	Strar's Signature	enderbre	deeDR	CRUL	nsulle M	21032					
	Sta Registr		net 0 3 2012 Zave	in B. of	The state of									

11011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 27, Richard Coffren 2012 8:35 A.M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Frederick 4b. City, Town, or Location of Death **Examiner** 5685 Pebble Drive Frederick Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign Months Days 578-48-7539 74 Hours Director 1 ₩ M 2 □ F Oct 2, 1937 Washington, D.C Usual Residence of Decedent 28a-f show aţ 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits Director must be notified Frederick Maryland Frederick 1 Yes 2 INO 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5685 Pebble Drive items 23a USA 21703 death v 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. 0 þ 1 Never Married 2 Married within 72 hours after Yes, Giv 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. white "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Meat Cutter Safeway 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert Coffren Louise McWilliamson and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Shirley Coffren - wife 5685 Pebble Drive, Frederick, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State St. Paul's Cemetery 10-2-2012 Waldorf, Maryland 4 ☐ Doynation 5 ☐ Other (Specify) Sign re of Funeral Segvice Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21701 2da. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phyliin/ ESOPHACEAL disease or condition resulting in death) MONITHS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exam Cause (Disease or injury burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Box 68760 as the t E FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Year Month Day Pregnant at time of death Other (specify) Yes 2 No the 9 Unknown 9 Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 □ Probably 4 □ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 X No certificate 1 Yes 2 No the Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director, After t Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical

7+1

John Lucas 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7190 Crestwood Boulevard, Frederick, Maryland

29d. Date signed (Month, Day, Year)

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0055154

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ JEAN ROBINSON CHILD September Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner lalbot Hospital at Easton Memorial astor If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8 Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Min. (Month, Day, Year) 84 Director 226-30-8361 1 🗆 M 2 🔀 F 1/19/1928 VIRGINIA Item 27 is marked other than "natural", or Items 23a or 28a-f shov other treumatic event, the Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🕅 No TALBOT ST. MICHAELS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21663 23916 MOUNT MISERY ROAD 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛛 No If Yes, Give 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 ☐ Divorced WHITE Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) id Mental Hyglene. markad other than Elementary/Secondary (0-12) College (1-4 or 5+) TRAVEL AGENCY TRAVEL AGENT 12 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ REBA BEAM CHARLES ARTHUR ROBINSON . Page 1 and 2 should b Imant of Health and Mer tant: If Item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)MD 21030 19a. Informant's Name/Relationship (Type, Print) GODFREY BYRD CHILD, JR./SON 10408 BARRETTS DELIGHT DRIVE, APT. J, COCKEYSVILLE, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State parmit. Page 1
Department of I
Important: If it
any injury or or 1 X Burial 2 Cremation 3 Removal from State OXFORD, MARYLAND OXFORD CEMETERY 10/02/2012 4 Donation 5 Other (Specify) 21. Signature f Funeral Se 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
200 SOUTH HARRISON STREET, EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death CHOLANGIOCARCINOMA Immediate Cause (Final Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the attending physician and ched for use as the burlal-transit or Attending Physician: The law requires that the death certificate be axecuted Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month 5 Other (specify) Pregnant at time of death this certificate has bean signed by the srail director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No filled in by the funeral director, 25. Was case referred to medical B 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of s after death. I Director: After t 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hoapital 624 hours a To the Hospital within 24 hours To the Funeral Completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier eles Bother 00059487 9-27-12 165

Registrar

DHMH 17 Rev 06-2011

State

219 SOUTH WASHINGTON STREET, EASTON, MD

21601

30. Name and accress of person who completed cause of death (Item 23a) (Type, Print)

JOHN BOTSIS, MD
31. Date filed (Month, Day, Year)
SEP 2 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 0330 M SE CC 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Arnold 420 West Joyce Lane If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral (Month, Day, Year) 110-14-0352 Director 1 □ M 2 🕅 F 87 New York Nov. 3, 1924 show 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene.

oortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director Arnold Maryland Anne Arundel 1 Yes 2XXNo 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code 21012 Funeral 420 West Joyce Lane 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ♠No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 20 No Specify: White Specify. 34√X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Education Professor 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adeline DiGianni ပ Anthony Aulisi permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 427 West Joyce Lane Arnold, Maryland 21012 19a. Informant's Name/Relationship (Type, Print)
Maria Colucciello/daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 D Burial 2 Premation 3 Removal from State 10/2/2012 Baltimore, Maryland Baltimore Crematory : 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of unera Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final ARTERY Physic an/ LORONARY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ě 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No မူ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number

State Registrar

100

31. Date filed (Month

who completed cause of death (Item 23a) (Type, Print)

2012

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Ma	aryland /	Departme <i>Certifica</i>				Reg. No.	12	33569	
Ä	Physicia		1. Decedent's Name (First, Middle, Last)						2. Date of De Month	Day	Year	3. Time of Death	
ph .	/Medic	al	4a. Facility Name (If not institution, give s	Oorsey Lee C	rockett	4b. Cit	, Town, or	Location of Death	09		2012 y of Death	3:25 P M	
	Examin	er	Alice Byrd Tawes		ne		,	Crisfield		S	Somerse	t	
À	Funeral Director		5. Social Security Number 6. Sex		e (In yrs. last bi	Yrs. If Und	er 1 Year Days	Hours Min.	8. Date of Bir (Month, Da 06/22/	th ly, Year) 1939	9. Birthp Coun Virg	lece (State or Foreign try) ginia	
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	vn or Location					1	0d. Inside City Limits	
	Aaryla f sho	ō		1 <sub>c</sub>			Т	angier				1 X Yes 2 ☐ No	
	28a-	Director	VA Accomac	Λ	<u> </u>	10f. Z	ip Code	angici		10g. Citizen of	What Cour	ntry?	
	h with	0	16149 Main Street				2	3440		1	USA		
	deat	Funeral		12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Dec	edent of Hi	ispanic Origin? (S) n, Mexican, Puert	pecify Yes or No o Rican, etc.)	)- 14. Ra Bla	ice - Americ ack, White,		
36	be filed within 72 hours after death with the Maryland tal Hygiene. ad other then "netural", or items 23a or 28a-f show event, the Medical Exertifier must be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 1 1 Yes 2 1 1 Yes, Give Year or Dates:	No		2 🔀 No	Specify:		Speci	ify: Whi	ite	
9	2 hou		15. Decedent's Edu	cation	168	a. Decedent's Us	ual Occupa	ation during most of wor	16b. Kind of Business/Industry				
21215-0036	thin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. DO NOT	IOT use retired)			S			
21	ed will ygien rer th	Con	9				Waterm	an 18. Mother's Nan	no (First Middle				
Maryland	of in b	Be	17. Father's Name (First, Middle, Last)	C1	44			10. 140(116) \$ 148(1		Crockett			
2	s 1 and 2 should I Health and Men Item 27 le marke other traumatic	은	19a. Informant's Name/Relationship (Ty	nnings Crock		b. Mailing Addre	ss (Street a	and Number or Ru				Code)	
_	12 ± 2		Dorsey Lee Crockett, Jr.			P.O. Be	ox 43, T	Tangier, VA	23440				
e,	of Health of Health f Item 27		20a. Method of Disposition		20b. Place cemet	of Disposition (Nery, crematory of	ame of other plac	ee)	Date	20c. Location	- City or To	own, State	
altimore,	Pages nent of I ant: If Its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F ¹ 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	Crocke	tt Family C	emeter	y	10/03/12	Т	angier,	VA	
Balt	permit. Pages Department of Important: If It eny Injury or o		21. Signature of Funeral Service Licens					ss of Facility Funeral Hom	ne P.O. Bo	x 1 Parksl	ev VA	23421	
	- 0 - B	- 1	23a. Pant. Enter the disease, or compl	ications that caused	the death. Do						, , , ,	Approximate Interval Between	
	Physician												
à	/Medical Examiner			b									
	pe is	liner	if any, leading to immediate cause. Enter Underlying		a consequence	a of).							
	and and al-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence	e of):							
8760,	icate be executed physician and s the burial-transit	dicall		d									
9	entifica ding pt	0	IF FEMALE:	23c. If yes, outcome	of pregnancy					224 0	ate of deliv	001	
Вох	that the death certificed by the attending placed for use as	Physiclan/M	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal dea	th 3 □Ectopic		′			Aonth	Day Year	
o.	tt the di by the tached	hysic	1 Yes 2 No	9□ Unknown			. ,,						
ds, P	es De De	by	Part II. Other significant conditions co	ntributing to death b	out not resulting	in the underlying	g cause giv	en in Part I.		tobacco use co		the cause of death?	
Vital Record	w requir been si should	Completed							24a. Wa:		. Were auto	opsy findings available	
Re	The lav le has age 2	omp								opsy ormed? 2 2 No	death?	ompletion of cause of	
ital		40	25. Was case referred to medical					26. Place of De	ath (Check only				
of V	Physician: this certificant	To B	examiner? 1 🗆 Yes 2 💆 No		ent 2 ER/0		7	4 / Nursing F	Home 5 Res			fy)	
o uc	Jing After fune		27. Manual of Death  Natural 5 Pending  Accident investigation	28a. Date of Inju (Month, Da	ay Year) 28b	. Time of Injury M	28c. Injur Wor	yat k? Yes 2 ⊡No	28d. Describe	how injury occ	urred		
Division	Atten r deat ector: by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of In building, e	jury - At home, tc. (Specify)	larm, street, laci	ory, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
1	Hospital or 24 hours afte Funeral Dir tely filled in	edical Co	29a. Certifier 1/ Certifying Phy (Check only 2 Medical Exam	rsician: To the best	of my knowled	ge, death occurr	ed at the til	me, date and place	e, and due to the urred at the time	e cause(s) and i	manner as : e, and due !	stated. to the cause(s)	
	To the H within 24 To the F complete	Medi	one)  29b. Signature and title of certifier	and manner st	tated.		29c. Licens			29d. Date sign			
•	1 w T 0		zau. Signatura and title of cannier	2 des				2981	7	101	12/	17	
	CA		30. Name and address of person who d	ompleted cause of	death (Item 23s	a) (Type, Print)	1	2100		75	->/	7	
	4		M ANIN	S ho	20	1 les	sel	Kleylin	my C	PUS P	elel	My	
15	Sta Regist	ate	31. Date liled (Month, Day, Year)		rar's Signature	1 4-	و بد		0		U.	877	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Clulee Physician/ 7:20 PM Caro 2012 notober . Medical own, or Location of Death 4a. Facility Name (if not institution Baltimor 4c. County of Death Hospita Examiner last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours **Director** 160-34-2220 68 1 M 2 X F Dec. 11, 1943 Oklahoma Usual Residence of Decedent r 28a-f show notified at 10c. City. Town or Location 10d. Inside City Limits 10b. Count Director 1 X Yes 2 No LaVale MD Allegany 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? or items 23a or ner must be n Funeral 21502 U.S.A. 12404 Gramlich Rd NW within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Bace - American Indian. "natural", or item ledical Examiner n 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic
once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Speech Language/Pathologist Healthcare 12 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Miriam E. (Fisher) Kipp Wade Mason Kipp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12404 Gramlich Rd NW, LaVale, MD 21502 Nicholas H. Clulee 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Oct 5, 2012 4 Donation 5 Other (Specify) Scarpelli Crematory Cumberland, MD Signature of Funeral Service License 22. Name and Address of Facility Hafer Funeral Service, PA tohn 1302 National Hwy., LaVale, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Part 1. Enter the disease, or commissions that Jacobs and Salah Sa Interval Retween Onset and Death Immediate Cause (Final "ul mongry Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): physician Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day Year Month 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy page 2 performed Yes 2 is certificate h director, page 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) 1 Yes 2**X** No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 5 Pending 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of RES - 000 OGober 2,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 800 orleans St Eugenie Shie 4 31. Date filed (Month State 18 Registrar

		uner irect
attimore, maryland 21215-0036	rmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	portains if the 21 search and require in years.  yi injury or other traumatic event, if a Medical Examination matter or injury or other traumatic event, if a Medical Examination.

		1 - State Registrar		Cert	ificate of i	Death		Reg. No.					
		1. Decedent's Name (First, Middle, La	st)				2. Date of De	ath		3. Time of Death			
Physic		Peter	James		Davis		Month 9 –	27-1	2 Year	6:15pm			
/Medi		4a. Facility Name (If not institution, given				Location of Deat			County of Death	0.13pm			
Exami	ier	Onla			Clinto			Pr	ince Ge	eorge			
E		DIAGIOIG		s. last birthday) _	If Under 1 Year	If Under 24 Hrs	8. Date of Bir	th	9 Birthr	place (State or Foreign			
Funeral Director			10XM 2□F 79		Months Days	Hours Min.		1933	Cour	h Carolin			
		Usual Residence of Decedent	, ,						NOTE	ir carorri			
land we		10a. State 10b. County	10c. C	City, Town or Loc	ocation 10					10d. Inside City Limits			
Mary f sh	ō	Maryland Dring	Coorgo Fo	restvi	116					1X Yes 2 □ No			
the 1	ect	Maryland Prince 10e. Street and Number	e George   To	TEBEAT	10f. Zip Code			10g. Citi	zen of What Cour	ntry?			
with	ā				20747				USA				
s 23	eral	2611 Luana Dr	12. Was Decedent Ever in	11 12 14		ispanio Origina (9	Specify Vee or No		14. Race - Americ	can Indian			
er de itam	n.	11. Marital Status	Armed Forces?	0.3. If	Yes, specify Cuba	ispanic Origin? (S ın, Mexican, Puer	to Rican, etc.)		Black, White,				
5-0036 72 hours after death with the Maryland natural, or Itams 23a or 28a-f show alcal Examinat must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 1 No If Yes, Give Year or Dates:	1	☐ Yes 2€ No	Specify:			Specify: Bla	ck			
hour hour	D T			16a Dagada	nt's Usual Occup	ation		1	nd of Business/In				
215-0036 Ithin 72 hours affi e. an "natural", or Medical Exam	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Give k	ind of work done	during most of wo	rking	100.10	ild of Businessani	adstry			
nd 2121 e filed within al Hygiene. t other than want, the Me	Ę	Elementary/Secondary (0-12)	College (1-4or 5+)	!	elf- Em			η	ruckin	α			
d 21 filled wi Hygien other th		17. Father's Name (First, Middle, Last	1				me (First, Middle	1	<u> </u>				
Maryland d 2 should be file th and Mental Hy ?? is marked oth traumatic evant	Be			avis		Mamie	•			_			
aryland should be and Mental s marked o	은	Anthony		C.		oung							
and is my		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other than "natural" or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at		Melva L. Colli				wood Dr							
O O		20a. Method of Disposition 1 □ Burial 2X Crematiog 3 □		Place of Disposi cemetery, cremi	ition (Name of atory or other plac	(e)	Date	20c. Lo	ocation - City or To	own, State			
Pages nent of int: If it		`4 □Donation 5 □ Other (Special		etropol	itan	9-2	8-12	Alex	kandria	. Va			
Baltimo permit. Page Department important: if any injury o		21. Signature of Funeral Service Lize	nsee /2	22.	Name and Addre		State State 1		Tell mulciple and the	***			
Depa Depa impo any in		Majaja to	atrew	Ād	lams Fu	neral H	ome Pa	, Aau	asco M	D 20608			
98-		23a. Int. Inter the disease, or con	plications that clused the de-							Approximate Interval Between			
TARRES - SA		23a. P. rt. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and one cause of the cluster of the control of the cluster											
Physician /Medical		disease or condition resulting in death)	a	1	nces								
Examiner			Due to (or as a conse	equence or):									
	10	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	equence of):									
ped list	Examiner	cause. Enter Underlying Cause (Disease or injury		4									
ecul and I-tran	xan	that initiated events resulting in death) Last	c. Due to (or as a conse	aguence of):									
60, be ea	E												
68760, tificate be executed g physician and as the burial-transit	d		_ d										
)X 68760, certificate be executed rding physician and ise as the burial-transit	/Medical	IF FEMALE:	23c. If yes, outcome of preg	22001									
	200	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 2☐Fe	tal death 3 🗆 E	ctopic pregnancy	,		1	23d. Date of delive Month	ery Day Year			
e de	S	1 □ Yes 2 □ No	4□Pregnant at time of 9□Unknown	death 5	Other (specify)			i i		,			
ecords, P.O. Bc law requires that the death as been signed by the atter 2 should be detached for u	Physician	9 Unknown					00. 014			h			
s the general bed	by	Part II. Other significant conditions	contributing to death but not re	sulting in the uni	derlying cause giv	en in Part I.				he cause of death?			
cord w require been si			· <u>·</u> ····				14	Yes 21	□ No 3 □ Prob	bably 4 ∐Unknown			
ecords, law requires t as been signe	Completed						24a. Was		24b. Were auto	opsy findings available ompletion of cause of			
ge h	E							ormed? 2 2 No	death?	21 <b>%</b> No			
Vital Fision of the vician of	O	25. Was case referred to medical				26 Place of De	ath (Check only		10100	2 229 10			
	0 0	examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatient	3□ DOA Oth	00		-	6 □Other (Specia	64)			
Phy Phy ral d	I	27. Manner of Death		28b. Time of	28c. Injur		28d. Describe			797			
June Afte	tlor	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	Injury		k? Yes 2 □ No							
Division for Attanding after death. Director: After	Certification:	3 ☐ Suicide 6 ☐ Could not I	De Blace of Injury At	homo farm etro			28f Location	Street an	d Number or Rur	al Route Number			
or A after Direct in by	ir.	4 Homicide determined	building, etc. (Spec	cify)	ot, lactory, cilico		City or To						
Dital Urs a urs a rai i		and a series of the series of											
DIVISIC To the Hospital or Attanowithin 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Exa	hysician: To the best of my ki miner: On the basis of exami										
the land 2 than 1 than 1 had 1	Aed	one)	and manner stated.		29c. Licens	o numbor		and Dat	to signed /Mogth	Day Your			
To To	e2	29b. Signature and title of certifier	1/6		29C. LICENS	e number		290. Dat	te signed (Month,	Day, rear)			
		Weller	1 Januar		03	7206		Sent	sihe 28.	2016			
200		30. Name and Address of person who	completed cause of death (It	em 23a) (Type, P	Print)	7 1	1		/ 1				
1000		William T. TANA	completed cause of death (Its VENTAN 1701)  32. Registrar's Sig	Luigh	Kunt, t	ar was	ingto, r	uny	Imc				
St	ate	31. Date filed (Month, Day, Year)	32. Régistrar's Sig	nature									
Regist	rair	100 03	WIL Denne	p. 10	Me								
DHMH 17 Rev 1/	2001												

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ <sup>D</sup>23, September 2012 2:35 P M <u>ee James</u> Elder Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Charlotte Hall Veterans' Charlotte, Hall MD. Home 9. Birthplace (State or Foreign 6. Sex 1 X M 2 D If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday, 8. Date of Birth **Funeral** (Month, Day, Country)
North Dakota Hours 72 **Director** 502-36-1869 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 No Mechanicsville Maryland | St. Mary's 10e. Street and Number 10g. Citizen of What Country? Funeral 20659 USA 36665 Whippoorwill Court death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 1 No If Yes, Givel 961-1964 Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after Completed by 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumatic assets. Elementary/Seconday (0-12) 12th. College (1-4 or 5+) Mechanic Auto Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည James Randall Elder Olga Wilhelmina Linquist 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>36665 Whippoorwill Ct. Mechanicsville, MD. 20659</u> Willett/ Daughter eanne 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Oct. 2, 2012 Suitland, MD. edar Hill Cemetery 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Huntt Funeral Home BO35 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) requires that the death certificate be executed physician and s the burial-trans arona that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 anding pluse as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ atte in the past 12 months? ξ Month Pregnant at time of death 2 No ed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of Haperlipio 24a. Was an page 2 Jas autopsy perform death? Hospital or Attending Physician: The L24 hours after death. Funeral Director; After this certificate hated filled in by the funeral director, page Pulmonara 1 Yes 2 No Yes 2 25. Was case referred to medic examiner? Be Place of Death (Check only one) 1 Yes 2 No Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 🗓 M6 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) n 24 hours the Funeral Direct and filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of 29d. Date signed (Month 2 d cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete X 9449

State Registrar egistrar's Signatu

33573

			1 - State OF IVE	aryiand / Depa <i>Cer</i>	tificate of De		rentai mygie Reg.		l has	00010
	Physicia	· · /	Decedent's Name (First, Middle, Last)				2. Date of Death		У 3	3. Time of Death
-	Medic	cal	Lynne Marie Eldridge		-		September			9:30 Ам
	Examin	er	4a. Facility Name (if not institution, give street and number) 426 Burnside Street Apt 5		4b. City, Town, or Lo			4c. County of Death  Anne Arunde1		
	Funeral			(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea		9. Birthplace	e (State or Foreign
	Director		Usual Residence of Decedent	48 Yrs.	Months Days	nours Willi.	2/5/1964		Country) Washir	ngton DC
	and show dat	ğ	10a. State 10b. County	10c. City, Town or Loc					10d.	Inside City Limits
	Mary 28a-f otifie	Director	Maryland Anne Arundel		An:	napolis				1 XYes 2 No
	ith the 23a or st be r	ralD	10e. Street and Number 426 Burnside Street Apt 5		10f. Zip Code	21403	10g.	Citizen of W USA	hat Country?	
	eath w tems a	Funeral	11. Marital Status 12. Was Decedent E		/as Decedent of Hisp Yes, specify Cuban,		cify Yes or No-		- American I	ndian,
36	after d I", or i camine	ρ	1 ★ Never Married 2 ☐ Married I ☐ Yes 2 ★ If Yes, Give	No	Yes, specify Cuban,  ☐ Yes 2 X No		Rican, etc.)		, White, etc.	
9	nours natura ical Ex	etec	3 ☐ Widowed 4 ☐ Divorced		ent's Usual Occupati		166	Specify:	White	
215	e. han "r Medi	3 Widowed 4 Divorced If Yes, Give Year or Dates.  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  Specify:  1 Li Yes 2 & No Specify:  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Bus life. DO NOT use retired								
121	dygien Hygien ther ti nt, the	Be C	12	Pott					sanry	
Maryland 21215-0036	기 (First, Middle, Last) 의 기 (First, Middle, Last) 의 기 (First, Middle, Maiden Surnam									
lary	should and N is ma aumat		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	g Address (Street and	d Number or Rura	Route Number, City	or Town, Sta	ate, Zip Code	9)
е, ⊾	and 2 : lealth em 27		Diane Willumsen - Daughter		Box 4104,					
nor	age 1 ent of I nt: If it		20a. Method of Disposition  1 ☐ Burial 2 😿 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispos cemetery, crem Baltimore	atory or other place)		· · ·		City or Town, ore, MI	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee							
<u> </u>	o a m Ce		Myelin Tillover		7 Duke of			nnapol	is, M	0''21401
b			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final			0.00			Inte	proximate erval Between set and Death
	Physician Medical		disease or condition	SEZU consequence of):	RE DI	SORDE	K		42	1 years
	Examiner	_	Sequentially list conditions, b.							1
	lsit ed	Examiner	if any, leading to immediate  Lause. Enter Underlying  Cause (Disease or injury	consequence of):						
	xecute n and ial-trar	Exa	that initiated events c	consequence of):	<u>.</u>					
092	ificate be executed g physician and as the burial-transit	ledical	d							
687	ertifica ding pl		IF FEMALE: 23c. If yes, outcome of	of pregnancy						
Box	e death certific the attending hed for use as	Physician/N	in the past 12 months?  1 Live Birth 2	2 🗌 Fetal death 3 🛄	Ectopic pregnancy Other (specify)		i i	23d. Date Mon	of delivery th Day	Year
P.O. E	t the d by the	Phys	g ☐ Unknown							
σ.	requires that the death cert been signed by the attendin should be detached for use	by	Part II. Other significant conditions contributing to death bu	it not resulting in the un	derlying cause given	in Part I.	23e. Did tobacc	\		use of death?  y 4 🗌 Unknown
ords	requir been should	Completed					24a. Was an			indings available
Sec	rsician: The law r s certificate has k director, page 2 s	omb					autopsy performed	2 pr		etion of cause of
tal	cian: T ertifica ector, p	Be	25. Was case referred to medical examiner?			of Death (Check	_	140	LI TES ZL	INO
ξ	Physic this c	မ	HOSDITAL:	nt 2 ER/Outpatient  28b. Time of	3 DOA Other:		me 5 Residence			
o uc	The state of injury at									
Division of Vital Records,	l or Atter after dea Director	Certificate:	3 Suicide 6 Could not be	y - At home, farm, stree (Specify)	et, factory, office	2	28f. Location (Street City or Town, Sta		or Rural Rou	te Number,
Ö	pital o		29a. Certifier ertifying Physician: To the best of r		accuracy at the time of					
	To the Hospital or Attending Physician: The law requires that the death certifulling 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Medical	(Check only one) 3 Certifying Nurse Practitioner: To the	amination and/or investig	gation, in my opinion,	death occurred at	the time, date and pla	ace, and due t	to the cause(s	s) and manner stated.
	To the To the common co		29b. Signature and title of certifier	W O	29c. License nu				(Month, Day,	
			30. Name and address of person who completed cause of de	YW, O,	1 13	0 101		10/1	12017	
	56		Robert Scott Eden My	2002 N		kwa A	nnevallis	MO	SYL	)}
	Stat Registra		31. Date filed (Month, Day, Year)  OCT 02 2012  32 Registrar	's Signature	Ne l	0				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ KENNETH EDINGER SEPT. 29, 2012 11:15P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY ROCKVILLE VILLAGE AT ROCKVILLE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthdav) 8. Date of Birth **Funeral** Days Hours Min. TULY 8, 1930 172-26-5800 PENNSYLVANIA Director 1**X** M 2 □ F 82 10c. City, Town or Location ROCKVILLE permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the <u>Medical Examiner must be notified at any injury</u> or other traumatic event, the <u>Medical Examiner must be notified at once.</u> 10d. Inside City Limits 10b. Count Director MD. MONTGOMERY 12 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 Funeral 9701 VEIRS DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give UNKNOWN
Year or Dates. Completed by Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2X No Specify 3 🗌 Widowed 4 🗎 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ MECHANICAL **ENGINEER** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
MARY MILLER **EDINGER** 2 STANLEY 19a. Informant's Name/Relationship (Type, Print)
FRANK MCGOVERN- EXECUTOR 19b\_Mailing Address (Street and Number of Rural Route Number City, of Town, State, Zin-Cade) 9701 VEIRS DR. , ROCKVILLE, MD. ZU 850 Method of Disposition 20b. Place of Disposition (Name of Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place)
TRINITY MEM.GARD. 10/5/2012 WALDORF, MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility 2222-WISCONSIN AVE., NW HYSONG CO., INC. WASHINGTON, DC 20007 21. Signature of Funeral Service Licent 200 CC0367 used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one complications are complicated as the complex of the comple Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this cartificate has been been after this cartificate and the funeral Director. the attending physician and ched for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for a in the past 12 months? Month Dav Year 2 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No ☐ Yes B B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29c. Ligense number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 55.m CHARLES KARESH-9701-DRIVE ROCKVILLE 20850 31. Date filed (Month, Day, Ye 32. Registrar's Sig State Registrar

12-07305 Bradley Eugene Fritz

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2	Û		2	3	3	5	7	5
---	---	--	---	---	---	---	---	---

		1- For State Certificate of Death Reg. No.								
Physicia		1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Vest								
ledical Exami	ner	Bradley Eugene Fritz September 27, 2012 0429 hrs								
Contract of the Contract of th		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Frederick Memorial Hospital  4c. County of Death  Frederick  Frederick								
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign	$\neg$							
Director		220-17-5078   1 N 2 F   34 Yrs.   Months   Days   Hours   Min.   11/13/1977   Foreign   Country) MD								
, h		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Location 10d, Inside City Limit								
ow any										
Maryland r 28a-f sbow ed at once.	ģ	MD Frederick Thurmont 10g. Citizen of What Country?	-							
Baltimore, MD 21215-0036  bernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other tranmatic event, the Medical Examiner must be notified at once	Director	10695 Salem Ave. 21788 United States								
with ms 23.	Fa	11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.								
r death or ite	Funeral	Never Mailled 2 Mailled 1 Yes 2 X No								
s afte	à	3 Widowed 4 X Divorced If Yes, Giva Year or Dates:  1 Yes 2 X No specify: Specify: White  15. Decedent's Education (Specify only highest grade completed)   16a. Decedent's Usual Occupation (Give kind of work done)   16b. Kind of Business/Industry	-							
2 hour	ted	Elementary/Secondary (0-12) College (1-4 or 5+)								
D36 thin 7 ne.	Completed	Printer Printing Company								
5-00 led wit Hygien other	ខ	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	$\neg$							
121 I be fi ental I arked	B	Michael Eugene Fritz Meldina J. Gaynor								
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. n 27 is marked other than	유	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19517 Elkridge Dr., Keedysville, MD 21756	1							
and 2 sealth 2 tem 2 traum		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	$\dashv$							
Baltimore, bermit. Pages 1 ar Department of Hee important: If ite		1 X Burial 2 Cremation 3 Removal from State crematory or other place) Resthaven Mem. Gardens 10/2/2012 Frederick, MD								
Itim nit. Pa artmen ortani	Resthaven Mem. Gardens 10/2/2012 Frederic  4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  1621 Oppossumtown Pike, Frederick,									
Depril		1621 Opossumtown Pike, Frederick, MD 21702	ļ							
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and								
Medical		Immediate Cause (Final disease a. Cardiac Tamponade Death								
		or condition resulting in death)  Due to (or as a consequence of):  B. Ruptured Myocardial Infarct								
	-	Sequentially list conditions, if any, leading to immediate b. Ruptureu Myocardia infract:  Due to (or as a consequence of):	$\dashv$							
	Examiner	Cause. Erner Universitying Cause (Disease or injury that initiated	_							
red nsit	Exa	events resulting in death) Last  Due to (or as a consequence of):  d.								
760, cate be executed physician and the burial - trans	Medical	UNPENDED AMENDED								
760, icate be physic the bur		IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live high 2 Fetal death 3 Figure pregnancy Month Day Year	٦							
ox 687 eath certific	cian	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year  4 Pregnant at time of death 5 Other (Specify)	Į							
Box e death c the atten ed for us	Physician	1 Yes 2 No 9 Unknown 9 Unknown								
P.O. es that the gned by t		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?	٦							
B, P ires the signe d be d	ed by	1 Yes 2 No 3 Probably 4 V Unknown	_							
w requ	Completed	24a. Was an autopsy findings available autopsy prior to completion of cause of								
Rec The lar	E	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No								
tal Recian: The certificate ector, page	Bec	25. Was case referred to medical examiner?	コ							
of Vital Records, ng Physician: The law requir the this certificate has been si meral director, page 2 should	10	Yes 2 No Inpatient 2 FR/Outpatient 3 DOA Survival Nursing Home 5 Residence 6 Other	4							
n of ding P	Ë	27. Manner of Death  28a. Date of Injury (Month, Day,Year)  28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No  28d. Describe how injury occurred								
SiO Atten r deatl ector: by the	cati	2 Accident Investigation   28e Place of Injury - At home farm street factory office building etc.   28f Location (Street and Number or Rural Route Number City	$\dashv$							
Division tal or Attendi rs after death. al Director: A	Certification:	3 Suicide 6 Could not be determined (Specify)								
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	٦							
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
FSFS	ž	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)								
		Carde Hollan O.C.M.E. September 28, 2012								
5		30. Name and address of person who completed cause of death (Item 23a)  Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223								
	The state of the s									
St Regist	ate	31. Date filed (Month, Day, Year) 2012 32. Registrar's Signature								

OPENE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mogh 2 Bay 20<sup>Year</sup>2 Joan Catherine Gomez 1:24P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9020 Parsonsburg Road Wicomico Delmar 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth Months Hours Min (Month, Day, Year) 216-30-8048 Director 78 1 □ M 2X F Balt. MD. 5-18-1934 other than "natura", or items 23a or 28a-f shorent, the Medical Examinar must be notified at 10a. State 10b. County Page 1 end 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Wicomico Delmar 1 Ves 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9078 Parsonsburg Road 21875 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2√ No If Yes, Give 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 🔯 Widowed 4 🗌 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adam Schubert Mary Hagen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew Gomez- Son 9020 Parsons Road, Delmar, MD. 21875 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State Sacred Heart Cem. 10-03-12 4 Donation 5 Other (Specify) Baltimore 22. Name and Address of Facility The Burbage Funeral 21. Signatur of Funeral Service Home 08 William Street, Berlin, MD. 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Knozen Metastatic disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physicien and erel Director: After this certificate has been signed by the ettending physicien and filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a Was an perform 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 1 Yes 2 2 1 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: Natural Accident 5 Pending Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29c. License number 10 -30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BN4 CASTAL filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Carrol Walter Guth Physician/ September 2012 Medical 4b. City, Town, or Location of Death Annapolis 4a. Facility Name (if not institution, give street and number) County of Death
Anne Arundel **Examiner** Sunrise of Annapolis Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Country 217-28-7426 **Director** 1 🛛 M 2 🗆 F 4/2/1925 Texas 87 Yrs. Usual Residence of Decedent 28a-f shov 0a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Maryland than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Maryland Anne Arundel Annapolis 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 108 Melvin Avenue 21401 Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes Give Specify: White 44-80 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Officer 0 US Army traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Nina Bertha Sutter Irwin Wilson Guth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 108 Melvin Avenue, Annapolis, MD 21401 Jean Guth - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date TBD 20c. Location - City or Town, State cemetery, crematory or other place)
Arlington National Cem. 1 X Burial 2 Cremation 3 Removal from State Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee Myelin 147 Duke of Gloucester St, Annapolis, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. th. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ for in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 No the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 other (Specify) Assula မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural injury Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

10~1 State

DHMH 17 Rev 06-2011

within 24 hor To the Fune completely f

Registrar

Medical

29a. Certifier

(Check only one

29b. Signature and title of certifie

Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

🖵 🚅 of tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

3altimore, Maryland 21215-0036

Box 68760

P.O. I

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 30,  $\mathbf{P}^{\,\mathsf{M}}$ Jon Joseph Grow Sept. 2012 6:00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 21349 Lentz Road Baltimore Parkton Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1, M 2 □ F Months Days Hours Director 494-44-8100 70 29, 1942 Arkansas June Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 XNo Director MD Baltimore Parkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21349 Lentz Road 21120 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ Nol. 960 — If Yes, Give Year or Dates: 1964 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 2 3 ☐ Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Detective-Sergeant Law Enforcement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Albert Grow, Jr. Elizabeth Lina Hamilton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6001 Altamont PL. Baltimore, MD 21210 Jennifer A. Grow/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date cemetery, crematory or other place)
Cremation Direct 1 ☐ Burial 2 🖾 Cremation 3 🖾 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 York, PA Service 21. Signature of Puneral Service Licensee 22. Name and Address of Facility JJ Hartenstein Mortuary, 24 N. Second St. New Freedom, PA 17349 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardi c or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for an a consequence offi sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant canditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 3 Probably 4 Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform certificate 1 □Yes 2 ☑No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certification pletely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 🗖 No 1□ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Matural 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of tertifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who pleted cause of death (Item 23a) (Type, Print) l 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

0,110
aiene
1

oseph Manley	Hard	1- For State	ate of Marylar		artment of		and	Menta	al Hyg		Reg. No	2 (		2 335	380
Physic	an/	Registrar  1. Decedent's Name (First, Midd	le,Last)						2.	Date of De	ath	J		3. Time of Death	
Medical Exam		JOSEPH MANLEY								Month Septemb	er 24	, 2012		1019 hrs	
		4a. Facility Name (if not institution		nber)	41	c. City, Tow	n, or Lo	cation of (	Death		- 1	c. County of	Death		$\neg$
		29789 Standish Stree				Easton						Talbot			
Funeral		5. Social Security Number		. Age (In yrs. I		If Under 1 Months	$\overline{}$	If Under 2 Hours	24Hrs. Min.					place (State or	ł
Director		220-74-2957	1 M 2 F	40	6 Yrs.	WIGHTIO	bays	riouro		12/30	)/ 15	765	real	KILAND	
<u>*</u>		Usual Residence of Decedent  10a, State 10b, County		110c City	Town or Locatio	n								10d. Inside City Lir	mits
w any			топ											1 Yes 2 X	
Maryland 28a-f show	tor	MD TAL	BOL	EAS'	TON	10f. Zip Co	do				10a C	itizen of Wha	at Count		
r 28s	Director	10e. Street and Number				2160					-	JSA	at Cour	u <b>y</b> r	
hours after death with the Maryland 'ratural', or items 23s or 28s-f she Examiner must be notified at once		29789 STANDIS		dent Ever in 11	C 112 W/22			nio Origin	2 / \$200	ify Voc or N			Amorio	an Indian, Black,	—
ath wi	uneral	11. Marital Status 1 Never Married 2 XM	12. Was Deced	ces?		s, specify C				ify Yes or N can, etc.)	0-	White,		an incian, black,	
er dez , or i	Н		1 Yes	2 X No		Yes 2 X	No. s	snecify:				Specify:	WHI	TE	
irs aft tural"	or Dates:  15. Decedent's Education (Specify only highest grade completed)  16b. Kind of Busine									iness/In	dustry	_			
2 -	during most of working life. DO NOT use retired)  Elementary/Secondary (0-12) College (1-4 or 5+)														
D36 thin 7 ne.	ldu	12	-0-	-	MECHAN	VIC.					SI	HEET M	ETA	L	
5-0(iled with Hygies	15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busing Market Parket														
21215-0036 und be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be														
	ြို										, State,	Zip Code)	- U		
ore, MD st l and 2 sho of Health and If item 27 is		STACEY ANN HAR 20a. Method of Disposition	DESTY/WIFE	1205						Date		Location - 0	City or T	Town State	_
ore, is larged by the contract of the contract		1 Burial 2 X Cremation	1 3 Removal fror	m State CH	Place of Disposit	p GRE	ATI	ÖN			1		-		
imore, MD 2 Pages 1 and 2 shou ment of Health and N tant: If item 27 is n or other traumatic		4 Donation 5 Other S	pecify:	C	ENTER				09/2	7/201	2 S'	TEVENS	VIL	LE, MD	
Baltimore, permit. Pages 1 a Department of He Important: If its injury or other t		21. Signature of Funeral Service	Licensos	01	· PE	LOWS	dress of	LTEN	BEIN	& NE	WNA	M FUNE	RAL	HOME, P.	.A.
		12 Rest	Figner	up ( )	Do not enter the	) S. I	LARR	ISON	ST.	EAST(	UN,	MD 21	901	Approximate Inte	levol
Physician Western		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										``	Between Onset a		
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Contact Submental Shotgun Wound  Due to (or as a consequence of):												-	
			b.	onsequence o											
	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	consequence o	f):										
	Examiner	(Disease or injury that initiated	c. Due to (or as a c	onsequence o	f):										
kecuted 1 and - transit		events resulting in death) Last	d.	7											
5 ਨੇ ਰ	dical	UNPENDED	AMENDED												
38760, rifficate be ing physic as the bur	¥ec	IF FEMALE:		utcome of preg	nancy						2	3d. Date of o	delivery		7
x 687 h certific ending p	an/	23b. Was decedent pregnant in the past 12 months?	I LIVE DIL	th nt at time of de	ath _	al death	_	Ectopic p	regnanc	у		Month	Da	ay Year	
Box 68760 death certificate be attending physic of for use as the bu	Physician/Me	1 Yes 2 No 9 Uni	known g Unknow		othe	er (Specify									
D. B trthe da by the	F.	Part II. Other significant condit			esulting in the un	derlying ca	use give	en in Part	I.	23e. Did	tobacc	o use contrib	ute to th	ne cause of death?	
ires that the signed by	ğ									1 Ye	es 2	<b>√</b> No 3	Proba	ably 4 Unknov	vn
ords, w requir	etec									24a. Was				opsy findings availa	
Division of Vital Records, tal or Attending Physician: The law requirers after dearth.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed	_			_	_		-	_	auto perfe 1 ✓ Yes	ormed?	? de	eath?		- 1
tal Rec		25. Was case referred to medica	i i			26.1	Place of	Death (C	heck onl	J	2	NO I	Yes	2 NO	
Vita bysician this cer	o Be	examiner? 1 ✓ Yes 2 No	Olfonoitale com	patient 2	ER/Outpatient						Resid	dence 6	Other:	Scene	
1 of Viling Phy	-	27. Manner of Death	28a. Date of	f Injury	28b. Time of Inj	ury 28c	Injury a	at Work?				njury occurre	d		$\neg$
on ath. br: A	[발	1 Natural 5 Pending Sep 24, 2012 1005 hrs 1 Yes 2 No Subject shot self													
VISI or Att her de directe	Lica		stigation 28e. Place	of Injury - At he	ome, farm, street	, factory, of	fice buil	ding, etc.	28			and Number	r or Rur	al Route Number, (	City
Division pital or Atten ours after death teral Director: filled in by the	Certification:	4 Homicide		Single Fan	nily Home				29	or Town, 789 Stand	lish St	reet, Easto	n, MD		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hourst after death.  To the Funeural Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		(Onlock Only)	hysician: To the best												
To the Hos within 24 h To the Fun completely	Medical	- (-)	miner:On the basis of and manner sta		nd/or investigatio				rred at th	ne time, date					
	Ž	29b. Signature and title of certific	1				cense n				7.5			th, Day, Year)	
715		Carde 1	talla	u			).C.M.	E.			Se	ptember	25, 2C	712	
6		30. Name and address of person				altimere	Stroot	Baltin	ore A	MD 21222					
·			Assistant Medica			ailiniore	Jueel	, Dailiff	ioie, N	ID 2 1223					_
		State 31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature 33.													

OCME

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	1 - State Registrar	Certificate of Death	7	Reg. No.									
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Dea	th Z Year 2 3. Time of Death 0									
	Medic	al	Margaret Elizabeth High		Octobe										
	Examin	er	4a. Facility Name (if not institution, give street and number) 12421 Stretton Lane	4b. City, Town, or Location Bowie	n of Death	4c. County of Death Prince George's									
	Funeral Director		5. Social Security Number   6. Sex   7. Age (In yrs. last birtl)   1	hday) If Under 1 Year If Under 1 Months Days Hours Yrs.		9. Birthplace (State or Foreign Country)									
			Usual Residence of Decedent		Apr. 13										
	Maryland 28a-f sho otified at	Director	10a. State   10b. County   10c. City, Town   Prince George's   10c. City, Town	or Location Bowie		10d. Inside City Limits 1   Yes 2 □ No									
	with the s 23a or 2	Funeral Di	10e. Street and Number 12421 Stretton Lane	10f. Zip Code	0715	10g. Citizen of What Country? USA									
980	1 and 2 should be filed within 72 hours after death with the Manyland if Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 25a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 ☐ Never Married 2★★ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1  Yes 2 No Specif		14. Race - American Indian, Black, White, etc. Specify: White									
21215-0036		Completed	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during mo- life. DO NOT use retired)	ost of working	16b. Kind of Business/Industry									
21	ed within Hygiene. other tha ent, the N	ادها	12	Secretary		Home Builders									
Maryland	should be filed n and Mental Hy 7 is marked oth raumatic event	To B	17. Father's Name (First, Middle, Last) Andrew Crockett	ther's Name (First, Middle, 18 Sabbette Metz											
	I and 2 shoul F Health and Item 27 is mi	19a. Informant's Name/Relationship (Type, Print) Paul C. High/ Spouse  19b. Mailing Address (Street and Number or Rural Route Number, City or Town 12421 Stretton Lane, Bowie, MD 20715													
Baltimore,	. 0	20c. Location - City or Town, State Crownsville, MD													
Balt	permit. Page Department of Important: If any injury or once.		eral Home , MD 20715												
			23a. Fart 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	as cardiac or respiratory arr											
	hydician/		shock, or heart failure. List only one cause on each line.												
	Medical Examiner		METASTATIC NOW SMALLCELL LUNG CAUSER 24 M												
		ner	if any, leading to immediate Due to (or as a consequence of	US NO NO MARINE	CONGC	TULEIC 29 MONIUS									
	uted id ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events  c.												
	e exection are urial-t	E E	resulting in death) Last Due to (or as a consequence of	nf):											
8760	tificate be executed ng physician and s as the burial-transit	Medical	d												
Box 687	death cert ne attendir ed for use	Physician/M	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ✓ No 9 □ Unknown  23c. If yes, outcome of pregnancy  1 □ Live Birth 2 □ Fetal death  4 □ Pregnant at time of death  9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year									
. P.O.	<b>∓</b> ∈ 0	þ	Part II. Other significant conditions contributing to death but not resulting in	, , ,		bacco use contribute to the cause of death?  'es 2 □ No 3 □ Probably 4 □ Unknown									
rds	been si	etec	Attoscenosis.	a zer z	24a. Was a										
Records,	has ye 2	Completed	HUBEITENSION.		autop	sy prior to completion of cause of death?									
tal	ysician: The s certificate director, paç	Be	25. Was a referred to medical examiner? Hospital:		eath (Check only one)										
of Vital	S S	안:	1 L Inpatient 2 L ER/Ou	tpatient 3 DOA Other: 4 Dime of 28c. Injury at	Nursing Home 5 Resid										
The second of th															
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (S City or Town	treet and Number or Rural Route Number, n, State)									
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, only one)  3 Certifying Nurse (vactitioner: to the best of my knowledge)	r investigation, in my opinion, death	occurred at the time, date ar	nd place, and due to the cause(s) and manner stated.									
	To the within To the Comp	-	29b, Signature and title of certifler	29c. License number	r:	29d. Date signed (Month, Day, Year)									
			· Marine	20019		10/1/12.									
	100		30. Name and address of person who completed cause of death (Item 23a) (  ROBERTO A. DEPETR	Jype, Print) 1430	WIE M	TRX 4# 122 D 20715									
	Star Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	had											

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

		4	For State	State of Maryland /		cate of De		-		
			Registrar  1. Decedent's Name (First, Middle, Last)		Cerum	cale of De	Jaur	2 Date of Death	eg. No.	3. Time of Death
	Physicia	n/		e Tolonso				Month	Day 5 Year	A 4466.76
	Medic Examin	al .	Bernice, Mac 4a. Facility Name (if not institution, give str	eet and number)	4b	. City, Town, or Le	ocation of Death		4c. County of Dea	
	Examili	51	3305 Lumar			-	ashinata	N	Prince	Georges
	Funeral		5 Social Security Number 6 Sex	7. Age (In vrs. last b.	oirthday) If	Under 1 Year	If Under 24 Hrs.	8 Date of Birth	9. Bi	rthplace (State of Foreign
	Director		26-40-4808 10	M 2×F 69	Yrs.	onths Days	Hours Min.	(Month, Day, 12-23	-1942	Delaware
	, A	. I	Usual Residence of Decedent	10- Cit. T-	Loostio					10d. Inside City Limits
	ylanc •f shc ed at	형	10a. State 10b. County		own or Locatio	4	1			1 D Yes 2 D No
	Mar 28a	Director		Georges to	~+ V	Vasha Of Zin Code	ration		Og. Citizen of What C	
	th the	اع	10e. Street and Number			207	11.1	'	USA	ountry?
	ith wi	Funeral	33 05 Lumo	2, Was Decedent Ever in U.S.	13 Was			ecify Yes or No-	14. Race - Am	erican Indian
·0	or ite	by Fi	1 Never Married 2 Married	Armed Forces?			panic Origin? (Spe Mexican, Puerto	Rican, etc.)	Black, Whi	
9	s afte ral", Exan	d be	3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates.	1 🗆	Yes 2 No	Specify:		Specify: Bl	ack
Maryland 21215-0036	within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation 16	6a. Decedent's	s Usual Occupati	ion ring most of work	ina	16b. Kind of Business	
2	in 72 e. nan "	Ĕ	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DO NO	OT use retired)		1	****** 2 -	
7	with ygien her ti	a	10				Worke		Facto	Ry
<u>n</u>	be filed vental Hyg rked oth ic event,	일 일	17. Father's Name (First, Middle, Last)					e (First, Middle, M		'
<u> </u>	Ild be I Mer narke natic	-		erson			Heler		om	
<u>a</u> a	12 should be file lith and Mental I 27 is marked o r traumatic eve		19a. Informant's Name/Relationship (Type					_	City or Town, State, Z	
	and 2 s Health tem 27 other tra		Vincent Dixon  20a. Method of Disposition		e of Dispositio				Shington - City o	MD 20744
סר	Page 1 nent of l ant: If it ury or o	1	1 🗷 Burial 2 🗆 Cremation 3 🗆 Re	emoval from State ceme	etery, cremato	ry`or other place)	į		•	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If team 27 is marked other than "natural", or items 23a or 28a-f show important: If the most is marked other than "natural" or items to enotified at any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee			metery me and Addres	of Facility 12	21-104	Preston,	uneval Home
Ba	permit. I Departn Importa any inju		3/ La de la companie	11.11.	44 "	11. The second			Fastonin	
			23a. Part 1. Enter the disease, or complice	ations that caused the death. D	o not enter the	e mode of dying,				Approximate
.,			shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	5/2/2/07/11	_				Interval Between Onset and Death
1	mysician/ Medical	î I	disease or condition resulting in death)	Due to (or as a consecuting	CQ1Cq	2				UNKNOWN
	Examiner			Dao to for as a conse of the						
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequenc	ce of):					
	ansit	ami	Cause (Disease or linjury that initiated events							
	exect	Ä	resulting in death) Last	Due to (or as a consequence	ce of):					
200	icate be executed I physician and Is the burial-transit	edical Examiner	d							
876	tificat ng ph as th		IF FEMALE:							
Ø X	ath certifica attending p	ian/	23b. Was decedent pregnant in the past 12 months?	<ul> <li>If yes, outcome of pregnancy</li> <li>1 Live Birth 2 Fetal de</li> </ul>		topic pregnancy			23d. Date of d Month	elivery Day Year
Box 68	deat he at hed fo	Physician/N	1 Yes 2 No	<ul> <li>4 ☐ Pregnant at time of death</li> <li>9 ☐ Unknown</li> </ul>	th 5 ∐ Ot	her (specify)			, , , , , , , , , , , , , , , , , , ,	54,
P.O.	requires that the de been signed by the should be detached		Part II, Other significant conditions conf	ributing to death but not resultir	ng in the unde	rlying cause give	n in Part I.	23e. Did tob	acco use contribute	to the cause of death?
σ <u>.</u>	es tha	d by						1 □ Y€	es 2 🗆 No 3 🗆	Probably 41 Unknown
rds	equir	etec	7					24a. Was ar	24b. Were a	utopsy findings available
000	law r has b	Completed						autops	y prior to death?	completion of cause of
m	i: The icate r, pag		25. Was case referred to medical			OF Dies	ce of Death (Chec	1 Yes	2 No 1 □ Ye	es 2 🗆 No
ita	I or Attending Physician: The law is after death.  Director: After this certificate has be in by the funeral director, page 2 s	) Be	ovaminer?	ospital:	/O. d did 6	Other			nce 6 Other (Spe	
Ť.	Phys r this ral di	<u>اب</u>	27. Mann of Death		b. Time of	28c. Injury a	at	28d. Describe ho		ectry)
n o	ding th. Afte fune	cat	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	Injury	work? M 1 □ Y	′es 2 □ No			
Sio	Atter	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home,	, farm, street,	factory, office			reet and Number or R	ural Route Number,
Division of Vital Records,	al or safte		A TISMINIA	building, etc. (Specify)				City or Town	, State)	
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transic completed filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Medical		ian: To the best of my knowledger: On the basis of examination and	ge, death occu	ired at the time, o	date and place, a	nd due to the caus	se(s) and manner as s	tated. e cause(s) and manner stated.
	he He in 24 he Fu	Mec	(Check 2   Medical Examine only one) 3   Certifying Nurse	Practioner: To the best of my kn	owledge, deat	h occurred at the	time, date and pla	ce, and due to the	cause(s) and manner a	is stated.
_	Vith Vor		29b. Signature and title of certifier	en m		29c. License		2	9d. Date signed (Mon	th, Day, Year)  26, 2012
			July rugoria	Let (		025	IUUI		seprense .	20120
	00:		30. Name and address of person who con	mpleted cause of death (Item 23: PMAN MO [86	Ba) (Type, Print	Armick	Or Ste	(XO 1 a)	september.	20774
	es i			32 Registrar's Signature	1 1 100	111111	VI JIL		1-	
	Sta Registr		31. Date filed (Manth Day, Year) SEP 2 8 2012	32 Registrar's Signature	bar	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Onth Onth 2012 JASPE R *15:35* Medical **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapou Anne Arunde If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours (Month, Day, Year) 501-20-2979 86 **Director** 1 M 2 AF North Dakota July 14,1926 item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 Yes 2 X No 10f. Zip Code 21403 10e. Street and Numbe 10g. Citizen of What Country? Funeral 12 Dogwood Road should be filed within 72 hours after death w and Mental Hygiene.

is marked other than "natural", or items. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 3 🖾 Widowed 4 🗆 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Tax Office Supervisor County Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Anton Oien Bella Haugen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Lani J. Schumacher / daughter 8169 Cedarcrest Court Denton, MD 21629 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of Important: If ite any injury or of X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery 10/03/12 Annapolis, MD 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licensee Ra 2973 Solomons Island Road, Edgewater, MD 21037 M01651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ days Medical resulting in death) Examiner Vear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or injury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d Date of delivery Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) in the past 12 months?
1 Yes 2 No Ectopic pregnancy Pregnant at time of death 1 Yes 2 9 Unknown been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available has page 2 prior to completion of cause of death?

1 Yes 2 No autopsy 1 Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ Inpatient 2 ER/Outpatient 3 DOA this To the mospine.

Within 24 hours after death.

To the Funeral Director: After thi 27. Manner eath 28a. Date of injury 28c. Injury at work?
1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Watural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Cordelia S. Johnson October 1 Day 2012 ear 6:49 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lanham Residence of Greenbelt Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. Funeral Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days Hours (Month, Day, Year) 214-24-2778 Director 1 M 2 X F 84 Oct. 16,1927 Maryland Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Lanham 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12500 Swirl Lane 20715 USA 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married β Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give 3 XXVidowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 0 Basil Duke Sollers Cordelia England 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12500 Swirl Lane, Bowie, MD 20715 19a. Informant's Name/Relationship (Type, Print) and 2 s Health Randall Johnson/Son other item 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of permit. Page 1 a
Department of F
Important: If ite
any injury or otl 20c. Location - City or Town, State Date cemetery, crematory or other place)
Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) Oct.1,2012 Baltimore, MD 21. Signature of Inheral Service 22. Name and Address of FacilityBeall Funeral Home 5512 NW Crain Hwy., Bowie, MD 20715 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 5 years Immediate Cause (Final disease or condition Alzheimer Type Dementia Physician. years Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or injury and -tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Osteoporosis 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 24 No page Hospital or Attending Physician: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 [X] No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes within 24 hours after death To the Funeral Director, A 2 🗌 No Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar 31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ICSON Physician/ Medical 4a. Facility Name (if not institution, give street and numb 4b. City, Town, or Location of Death Examiner æ thday) If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last b 8. Date of Birth Birthplace (State or Foreign Country) Days (Month, Day, Year) Director 1 ፟ M 2 □ F 251**-**74**-**4316 1944 South Carolina 68 20 27 is marked other then "neturel", or Items 23a or 28a-f show treumatic event, Ira Modical Examer marke mittind at filed within 72 hours efter death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Greenbelt 1 X Yes 2 No Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8150 Lakecrest Drive # 312 20770 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Never Married 2 Married Black, White, etc. Š 1 Yes 2 XNo Maryland 21215-0036 1 ☐ Yes 2 🗗 No 3 Divorced Completed **Black** Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest Hygiene. National Imagery & Elementary/Secondary (0-12) 12thCollege (1-4 or 5+) Carto Texh Mapping Agency end Mental Hygie is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ഉ pe q Janie Hinton James Henry Jackson end 2 should be Health end Me tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20770 Fannie Mae Jackson - Wife 8150 Lakecrest Drive #312 Department of Health Importent: If Item 27 eny Injury or other tr Greenbelt, Maryland Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗍 Removal from State Oct. 4 Donation 5 Other (Specify) 2012Ft. Lincoln Cemetery Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home, John Sewar M00560 4001 Road NE Benning Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examin attending physician and for use es the buriel-transit The lew requires that the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month been signed by the should be detached 9 Unknown P.O. ignificant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records. Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of page 2 autopsy After this certificate Yes 2 No 1 Yes 2 No To the Hospital or Attending Physiclen: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case refe of Vital Be 26. Place of Death (Check only one) ဂ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury work? Division 2 🗆 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only o 29b. Signature 65M ath (Item 23a) (Type, Print)

State Registrar 7600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene TCHD, 10/2/2012. TLS For State Registrar Amended 29d 33586 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Year SEPT. PETER V. KROUSE 27, 9:30 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9652 LEEDS LANDING CIRCLE EASTON TALBOT 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Country) 80 Director 159-30-8440 1 X M 2 □ F JUNE 14, 1932 PENNSYLVANIA Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director TALBOT EASTON 1 Yes 2 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 9652 LEEDS LANDING CIRCLE 21601 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. "natural", or 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) INDUSTRIAL Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) ENGINEER CONTROL INSTRUMENTS Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ DANIEL H. KROUSE JOSEPHINE WILDMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ISOBEL M. KROUSE, WIFE 9652 LEEDS LANDING CIRCLE, EASTON, MD 21601 Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) permit, Page 1 s
Department of H
Important: If ite
any Injury or ot Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FRIENDS BURIAL GROUNDS 10/3/2012 LANGHORNE, PA Signature of Funeral Service Licensee r ELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 0H2 MERCERON 1200 SOUTH HARRISON STREET, EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus: on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, heading to immediate cause. Enter Underlying Due to for as a ponsequence of sate has been signed by the attending physician and page 2 should be detached for use es the burial-trensit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 No 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 Yes 2 No Yes 2 DIN To the Hospital or Attending Pnysician: 1 within 24 hours after death.

To the Funerel Director: After this certifical completely filled in by the funeral director; 1 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**V**No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 - Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29c. License number 29d. Date signed (Month, Day, 1994) 27 / 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAROLYN R. HELMLY, MD 508 IDLEWILD 125 508 IDLEWILD AVENUE, EASTON, MD 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 01 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 28 2012 5:20 а м James Britten Miller Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8 Date of Birth Birthplace (State or Foreign Country) Days Hours (Month, Day, Year) Director 195-34-9092 May 26, 1946 Pennsylvania 66 Usual Residence of Deced 28a-f shov 10a, State the Maryland 10c. City, Town or Location 10d. Inside City Limits Directo ms 23a or 28a-f si must be notified 1 X Yes 2 No Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with tment of Health and Mental Hygiene.
Int. If item 27 is marked other than "natural", or items 23a ury or other traumatic event, the Medical Examinar must be 219 Sandstone Drive 21793 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever Armed Forces? 1 ☑ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. White 1 ☐ Yes 2 🖾 No 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Computer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ James B. Miller Beryl Baumbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Miller / Wife 219 Sandstone Drive Walkersville, Maryland 21793 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 1 Burial 2 Cremation 3 Removal from State njury or 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 1, 2012 Frederick, Maryland permit.
Departn
Imports
any Inju 21. Signature of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ogset and Death Immediate Cause (Final disease or condition Physician Arterios dero Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events vertens, Examine Due to as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certificate: To 2 No 1 Inpatient 2 KER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 🔼 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) with my 10030020 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Shutta W. M PO BOX 310 vhn 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Wallace Ρ. Mercer, 8:25 Medical September 201 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Citizens Care and Rehab Center Frederick Frederick Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Hours Director 142-24-3802 1 X M 2 - F 80 10/15/1931 New Jersey 10a. State 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f s notified 1 X Yes 2 No Frederick Point of Rocks 10e. Street and Number ō items 23a or ner must be n 10g. Citizen of What Country? Funeral 1612 Gibbons Road 21777 United States death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give 10515 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or iter edical Examiner þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify 3 Widowed 4 Divorced Specify: White Completed Year or Dates. 1951-55 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ntal Hygiene. ed other than " event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o 2 Page 1 and 2 should be Wallace P. Mercer, Jr. Jean A. Byrnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 i Edna Mercer / wife 1612 Gibbons Rd, P.O. Box 69, Pt. of Rocks, MD 21777 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) cof P : If it 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department Important: I any injury o Resthaven Mem. Gardens 9/29/2012 Frederick, MD 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final BLADRER CANCER Monset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): that initiated events Due to (or as a consequence of): resulting in death) Last d by the attending physician detached for use as the buria Physician/Medical certificate be the SS IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death Other (specify) 1 Yes 2 9 Unknown 2 No 4 ☐ Pregnam: 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 X Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No after death.

Director: After this certificate death?
1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 \( \sum \text{Yes} \quad 2 \sum \text{No} \) 1 Natural 5 Pending injury

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician:

within 2 To the State

24 hours

Medical

Registrar DHMH 17 Rev 06-2011 Accident

3 Suicide 4 Homicide

29a. Certifier

(Check

only or 29b. Signatu Investigation

determined

6 Could not be

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ress of person who completed cause of death (Item 23a) (Type, Print)
EEN BOCANUM, 196 TT DRIVE, FREDENCE, MD 21.702

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

00062223

28f. Location (Street and Number or Rural Route Number, City or Town, State)

9/26/2012

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 30 3012 Physician/ Month Cornelius M. McNamara 2:20A M ptember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7 HARLES EDICAL ENTER LATA Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) 116-10-2620 **Director** 1 🕅 M 2 □ F 90 June 24,1922 New York Usual Residence of Decedent or items 23a or 28a-f show 10a. State MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Charles Charlotte Hall 1 🗆 Yes 2 🖁 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29449 Charlotte Hall Road 20622 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Was Deceus...
Armed Forces?
1 X Yes 2 No
Navy 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor Escalator Division N.Y. City TransitAuth. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Cornelius McNamara Emily Moran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Jacobsen/Daughter 2011 Huntcliff Dr., Gambrills, MD 21054 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Rockland Cemetery 10/03/2012 Sparkhill, NY 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beall Funeral Home Signature of Fune Service Licenses 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List ook Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as ponsequence of **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): ysician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 ρh IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown certificate has been si irector, page 2 should i 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Hospital: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Man or of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

24 hours after death.
Funeral Director: After this etely filled in by the funeral of within 24 hor To the Fune completely fi

10 x1

State Registrar

(Check

only one)

29b. Signature and title of certifie

30. Name and address of person who completed cause of SUDHAKAR V.L.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year,

death (Item 23a) (Type, Print)

5 GARRETT AVE LaPlata, Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Claire McHugh 10:00 AM September 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Emeritus at Woodward Estates Prince George's Bowie **Funeral** Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 212-16-9357 **Director** 1 🗆 M 2 🔀 F 90 Maryland May 29, 1922 Usual Residence of Decedent 28a-f show 10a. State must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 X Yes 2 No 10e. Street and Numbe 9 10f. Zip Code 10g. Citizen of What Country? 5 Park Place, Unit 515 er tnan "natural", or items 23a the Medical Examiner must be Funeral 21401 U.S.A. filed within 72 hours after death Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Yes 2XXNo
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White Specify: 3 X Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever Harry Wise Ruby Southworth Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Daniel McHugh/son 5 Park Place, Unit 515, Annapolis, MD 21401 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State Baltimore Crematory 10/3/2012 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Si police Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 0 147 Duke of Gloucester St., Annapolis, MD 21401 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. advance Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of the burial-tran Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 ası IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) 4 Pregnant a
9 Unknown Pregnant at time of death 9 Unknown p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy the Hospital or Attending Physician: The fine 24 hours after death.

the Funeral Director: After this certificate the Funeral Director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**X** No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the within 2 To the Comple only one) 29b. Signature and title of certifier 29d. Date signed (Month, 2012 u 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Phry soition DIMARZIO MD 2003 State

Registrar

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAHON 205 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 8. Date of Birth (Month, Day, Year) Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Days Hours 517-14**-**7893 **Director** 1 🖾 M 2 🗆 F 95 June 5, 1917 Montana Usual Residence of Decedent or 28a-f show notified at 10c. City. Town or Location 10d. Inside City Limits Directo Maryland Prince George's Hyattsville 1 🛛 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 5707 39th Avenue 20781 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 ☒ Yes 2 ☐ No NAVY Black, White, etc. 1 Never Married 2 Married ò Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White Year or Dates. 1942-1946 "natural", Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Hygiene. Department of Elementary/Secondary (0-12) College (1-4 or 5+) the Information Specialist Agriculture 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental h r is marked ot 2 Edith Fishburn Myers Frank Edmund McMahon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Brian J. McMahon / Son 4 Walters Way, Pasadena, MD 21122 Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery 10/5/2012 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 rofer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest r heart failure. List only one cause on each line. 23a. Part 1. shock, Approximate Interval Between Immediate Cause (Final Physician/ SPIRATURY disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** umoni DIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due 1 (or as a consequence of): ٧ Exam burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 as the IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy łó in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No ate has been signed by the page 2 should be detached g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 1 within 24 hours after death. To the Funeral Director: After this certifica Division of Vital filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 NO ဂ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work?
1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier 🛮 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) Signature and title of certifier 29c. License number eurha

DHMH 17 Rev 06-2011

State Registrar

245M

31. Date filed (Month, Day, Year,

DEFENSE

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Oct 1,3abeth S. Macomber 2012 3:45 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 3551 Prospect Road Street 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 8/26/1920 217-62-3086 Director 92 1 M 2 X MD en "netural", or Items 23e or 28e-f show Medical Examiner must be retified at end 2 should be filed within 72 hours after death with the Maryland Heelth end Mentai Hygiene. tem 27 is merked other then "netural", or Items 23e or 28e-f show ther treumatic event, the Madigal Examiner in ust be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Harford Street MD 1 Yek 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21154 USA 3551 Prospect Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: sawhite Completed 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ L. Proctor Evelyn James Clarence Ε. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1402 Balsam Court, Forest Hill, MD 21050 John Macomber- son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Depertment of Importent: If It eny Injury or o cemetery, crematory or other place)
Evans Cremation Svc 10/10/12 1 Burial 2 Decremation 3 Removal from State Leola, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fohera Service Licensee 22. Name and Address of Facility Harkins F.H. Inc., Delta, PA 17314 over 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospitel or Attending Physicien: The iew requires that the deeth certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending the hours and sete has been signed by the ettending physicien end page 2 should be deteched for use es the buriai-trensit Cause (Disease or Injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown anemia Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Dementil death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 🔏 Residence 6 🗆 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License numbe 173/295 10/9/12

Registrar
DHMH 17 Rev 06-2011

State

Kenusaad

stre

Baltomore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8

31. Date filed (Month, Day, Year)

57e1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nutwell Physician/ Month 09 2012 helma 30 02:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** La Plata Charles County Nursing & Rehab Cntr Charles 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** Months Hours **Director** 1 M 2 X F 220-16-4388 06-10-1914 Maryland Usual Residence of Decedent 28a-f show Department of Health and Mental Hygiene. Important: If items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No Maryland Charles La Plata 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20646 United States 10200 La Plata Road Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, Armed Force by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Specify: 3 😾 Widowed 4 🗆 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Transportation School Bus Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mamie Hodges James Edward Goldsmith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2905 Chestnut Drive Waldorf, Maryland 20603 Patricia Barber/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Christ Church-Wayside 10-06-2012 Newburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Arehart-Echols Funeral Home, P.A. Taril 211 St. Mary's Ave. La Plata, Maryland 20646 M00945 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician . disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, eaching to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and ately filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \sum Yes 2 \sum No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 2 Accident
3 Suici 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 10/02 2012

Registrar

DHMH 17 Rev 06-2011

Dr. Jos in

Registrar's Signat

Vazhappilly

3 2012

bause of death (Item 23a) (Type, Print) on Blud Ste B, Gilen Burnumo, 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Steven Cameron Newsome 2012 10:56 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PARK IN ASHINGNO POVENTIT HOSPIML MAKOMA Mair Gome R' Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days Hours Min (Month, Day, Year) Director 231-72-3534 1 🖾 M 2 🗆 F Sept. 11, 1952 Virginia 60 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10d. Inside City Limits death with the Maryland other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 X Yes 2 No Hyattsville Prince George's Marvland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 6320 20th Avenue 20782 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other transmissions. 2 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No African If Yes, Give Year or Dates Specify: American 1 Yes 2 No Specify 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Government Director Museum Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Barbara E. Newsome 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 530 N Lake Street #28 Grayslake, IL. Sanya K. Newsome - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Oct. 4. 1 🗆 Burial 2 🖾 Cremation 3 🗖 Removal from State Lee's Crematory Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, 20019 4001 Benning Road NE Washington, DC M00560 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END Stage Rence DIsage Physician/ disease or condition Medical resulting in death) Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Day to for as a consequence of: Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed tending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 Yes 2 No certificate has been signed by the irector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No director, 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 잍 124 hours after deam. Je Funeral Director: After this only filled in by the funeral di 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne f Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Watural 5 Pending 1 Yes 2 No м ☐ Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 1 Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Funer

completely file 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 10-01-2012 55M experson who completed cause of death (Item 23a) (Type, Print) Canoll Ne Mxoma 7600 31. Date filed (Month, Day, Year) 2. Registrar's Signa State Registrar

	State of Maryland / Department of Health and Mental Hygiene 2012 33595											
			For State	State of Marylan			vientai Hygien	e 2012 33596				
			Registrar	Al	Certifica	te of Death	Reg. I					
	Physicia Medic		1. Decedent's Name (First, Middle, Las ABBAS	NAMJOL	1		2. Date of Death Month	3. Time of Death 12:00 M				
	Examir	er	4a. Facility Name (if not institution, give Mortgomery V	street and number) Con	N	y, Town, or Location of Death	Village	1c. County of Death				
	Funeral Director		217-39-93 191	7. Age (In yrs. la	S Yrs. If Und Month	der 1 Year   If Under 24 Hrs. s Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birthplace (State br Foreign				
	/land f show ed at	tor	Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Location	\ /'1\		10d. Inside City Limits				
	the Mar a or 28a- be notifi	Funeral Director	MD Mantgo	mery Ma	ntgomen 10f. 2	Code	10g. (	Yes 2 No  Citizen of What Country?				
	th with ms 23 must	nera			ane	20886		1.S.A.				
1215-0036	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status  1 □ Never Married 2 → Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates.	If Yes, sp	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White				
5-(	"2 hou "nate	Completed	15. Decedent's E (Specify only highest gra		16a. Decedent's Us (Give kind of v life, DQ NOT u	ork done during most of wor	Vina 1	Kind of Business Industry				
121	thin 7 ene. than he M	-rantan Armu										
d 2	ed wi Hygie other ent, t	Be (	17. Father's Name (First, Middle, Last)	<u> </u>	Militar	<del>-</del>	ne (First, Middle, Maide					
lan	Elementary/Seconday (0-12)  College (1-4 or 5+)  Iffe, DO NOT use retired)  Hill tarry Officer  Army  18. Mother's Name (First, Middle, Maiden Surname  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S  20a. Method of Disposition  20a. Method of Disposition  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place) Coln.											
Maryland	should and N is ma auma		19a. Informant's Name/Relationship (T)	100		ss (Street and Number or Ru		2001				
Σ.	nd 2 selection may be made to the mage of		Sattar Nam		20505	Aspenwood						
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other once.		20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State	Place of Disposition (Nemetery, crematory of	other place) Con		Location - City or Town, State				
Iţi	permit. Page Department Important: I any injury o once.	1	4 Donation 5 Other (Specif	1,11	- firdau		2 2012 -	ederick MD				
Ва	permit. Departr Importa any inju		21. Signature of Funeral Service Licens	MO#1070	22. Name	and Address of Facility A	den Muslim	1 1/0				
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
F	nysician/	5 /	Immediate Cause (Final disease or condition	Se ocis				Interval Between Onset and Death				
	Medical Examiner		resulting in death)	a. Due to (or a a consequ	uence of):							
	LAMITHUE	ī.	Sequentially list conditions, if any, leading to immediate	b. — Barta (annual annual annu								
	ed sit	Examiner	cause. Enter Underlying  Cause (Disease or impury	Due to (or as a consequ	dence oi):							
	be executed sician and burial-transit		that initiated events resulting in death) Last	Due to (or as a consequ	uence of):							
	e be exe ysician ie burial	lical		d								
9289	tificat ng ph as th	Mec	IF FEMALE:									
Box 6	death certificate k ne attending physi ed for use as the k	Physician/Medi	in the past 12 months?  1  Yes 2 No	23c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	al death 3 🔲 Ectopi			23d. Date of delivery Month Day Year				
P.O.	that the des ned by the s detached t		9 Unknown  Part II. Other significant conditions or	ontributing to death but not res	ulting in the underlyin	g cause given in Part I.	23e Did tobacco	use contribute to the cause of death?				
Js, P	uires th in signe uld be c	ed by	CVA					2 No 3 Probably 4 Unknown				
Records,	law require has been si e 2 should	Completed by	Advanced	Dementio	4		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?				
A.	ician: The la certificate ha rector, page		25. Was case referred to medical			00 Blazz ( Basil (0)	1 ☐ Yes 2 🛂					
/ita	siciar certii irecto	To Be	avaminar?	Hospital:	ER/Outpatient 3	26. Place of Death (Chec	lome 5 Residence	C Other (Connife)				
of Vital	iding Physician: " th. After this certifical funeral director, p		27. Manner of Death	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?	28d. Describe how inj					
on	The partial of the pa											
Division	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  with Puneral Director, After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	al Certificate:	4 Homicide determined	building, etc. (Specify	)		City or Town, Sta					
	the Hosp hin 24 hou the Funer upleted fil	Medical	(Check 2 Medical Exami	sician: To the best of my knowled ner: On the basis of examination se Practioner: To the best of my	and/or investigation,	n my opinion, death occurred	at the time, date and pla-	ce, and due to the cause(s) and manner stated.				
	To the company of the		29b. Signature and title of certifier	ch.v		gc. License number	29d. [	Date signed (Month, Day, Year)				
	1JW		• //			0-64168	10	0 2 2012				
	·aw		1 1 1001	completed cause of death (Item	1 23a) (Type, Print)	lecular Dr	, #206, R	ockville, MD				
,	Sta Registr		31. Date filed (Month, Day, Year)	2 Registrar's Signar	ure parket		,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Herbert H. Parsons, Jr. 7 a. September 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick 2407 Jennifer Court Clarksburg Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Hours Director 145-10-1961 1 XM 2 □ F 98 03/02/1914 New Jersey Usual Residence of Deceder 10a. State 10c. City. Town or Location notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 X No MD Clarksburg Frederick 10e Street and Number ō 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 2407 Jennifer Ct. 20871 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or iter Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify White Completed 3 X Widowed 4 ☐ Divorced Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Owner/operator Marina Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h မ Herbert H. Parsons, Sr. Irene Goad 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Penny Gole / daughter 2407 Jennifer Ct., Clarksburg, MD 20871 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) o = 0 1 🔲 Burial 2 🕅 Cremation 3 🗆 Removal from State Department Important: If any injury or Stauffer Crematory 10/3/2012 4 Donation 5 Other (Specify) Frederick, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) /Chronic Obstructive Pulmonary Disease 10 years Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician be detached for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 N this certificate 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 24543 September 28, 2012 am

Registrar

DHMH 17 Rev 06-2011

State

20906

James A. Rossi, MD / 3305 N. Leisure World Blvd, Silver Spring, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 arson 0034 M Dx0 SEM Medical 4a. Facility Name, (if not institution, give street and number) **Examiner** 4c. County of Death Grove Shad Mor greents thersbu Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthda) 8 Date of Birth (Month, Day, Year) **Funeral** 9. Dirthplace (State or Foreign Days Director 1 □ M 2 K F 145-16-7581 91 05/07/1921 New Jersey item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Evaniner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Frederick 1 Yes 2 No Clarksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2407 Jennifer Ct. 20871 United States filed within 72 hours after death al Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) School teacher Education permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Importent: If item 27 is marked othe any injury or other traumant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Henry Hoffman Edith Bugh PARSONS, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penny Gole / daughter 2407 Jennifer Ct., Clarksburg, MD 20871 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Stauffer Crematory Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 10/3/2012 Frederick, MD 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ grantro Intentin disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Compression Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury mo Hospital or Attending Physician: The law requires that the death certificate be executed Cerebrovas signed by the attending physician and id be detached for use as the burial-trans accident that initiated events resulting in death) Last Due to (or as a cp Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Other (specify) Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? cate has been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Mary Yes 2 No in 24 hours are. ... the Funeral Director. After this ... |요 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 2 Accident 5 Pending 57id out of bed onto Investigation 08/28/2012 0230 1 🗆 Yes 2 🔀 No 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 2407 Jennifer Ct. Clarksburg, Naryland home Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifier G'- Swapna 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockwell, Min lond Gaddipati 9901 Medical center Drive, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

24,2012

September.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death <sup>Day</sup> 25 Physician/ 2012 12:00 September Palmer Margaret Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 10 Sylvia Circle Thurmont If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 220-30-6406 Director 1 M 2 X F 79 Sept. 18, 1933 Maryland Usual Residence of Decedent 28a-f show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral [ 10 Sylvia Circle 21788 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White If Yes, Give Year or Dates 3 X Widowed 4 Divorced er than "natur , the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) of ith and Mental Hygien 27 is marked other the r traumatic event, the Medical Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Milton Hecker Christina H. Sommer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21042 If item 27 i or other tra Bruce Palmer / Son 3030 Greenhaven Court Ellicott City, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or conce. cemetery, crematory or other place) September 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 26, 2012 Stauffer Crematory Frederick, Maryland Signature of F uperal Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Frederick, Maryland 21702 1621 Opossumtown Pike 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) 10ac Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No for Month Pregnant at time of death Day Year detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? has page 2 performed? Yes 2 N 1 Yes 2 No funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Director: After 1 Natural 5 Pending 1 Yes 2 No the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by ☐ Homicide determined 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

oistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

pe or Print in Black indelible ink. Ensure All Copies Are Legible.	
State of Maryland / Department of Health and Mental Hygiene 2 0   2	33600
Certificate of Death Reg. No.	
2 Pate of Pageth	O Time of Dooth

			for State	State of Ma	aryland / Dep			ental Hy	giene (	2012	33	600	
			Registrar		Ce	rtificate of	Deam	2. Date of De.	Reg. No. of Death 3. Time of Death				
	Physici	an	Decedent's Name (First, Middle, Last		ъ.			Month	Day	Year			
	/Medio		An English Alama //f not institution give	W. Howard	Peterson	4h Cihi Toum	or Location of Death	Octobe		2012 County of Death	2224	P M	
	Examir	er	4a. Facility Name (If not institution, give 6159 Telegraph R			E1ktc		Cecil					
-	Consent		5. Social Security Number 6. S						8. Date of Birth 9. Birtholace (SI				
	Funeral Director			MXM 2□F	84 Yrs.	Months Days	L	(Month, Da	y, Year) 1927		Mary		
	D		Usual Residence of Decedent					XOV					
	how	_	10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside C	,	
	Ba-f.	cto	Maryland Cecil		E1kton							2 <b>X</b> No	
	or 2	Dire	10e. Street and Number			10f. Zip Code				en of What Cou	•		
	ath w	rai	6159 Telegraph R			2192				ited St			
	er de	une	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of If Yes, specify Cul	Hispanic Origin? (Spe pan, Mexican, Puerto I	cify Yes or No Rican, etc.)	- 1	<ol> <li>Race - Amer Black, White</li> </ol>			
36	irs aft	Completed by Funeral Director	1 ☐ Never Married 2 📆 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 1 1 1 1 Yes, Give 1 1 Year or Dates:	40	1 ☐ Yes 2 💢 No	Specify:		5	Specify: White			
Maryland 21215-0036	within 72 hours after death with the Maryland ane then "natural", or items 23a or 28a-f ehow ha Madical Examiner must be notilled at	ted	15. Decedent's Ed	Jucation	16a. Dece	dent's Usual Occu	pation		16b. Kin	d of Business/l			
215	hin 7	pie	(Specify only highest gra	College (1-4or 5	life.	DO NOT use retire							
21	er the	Son	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2	As	sistant	Vice Presi	dent	В	anking			
pu	al Hy	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, La Ga11		Surname)			
yla	Meni Meni arke	ပို	Paul Whitaker P	eterson									
lar	12 should be filed within h and Mental Hygiene. 7 is marked other then "Iraumatic event, the Men		19a. Informant's Name/Relationship (				t and Number or Rura ph Road, E			Town, State, Z. 21921	ip Code)		
	1 and 2 Health tem 27		Lillie S. Peter	son/wire	20b. Place of Disp	A 10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		ate					
Baltimore,	S = 0	,	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		Head of Presbyte	matory or other pla Christia:	na Octo	ber 8,		ation - City or 1 ewark .			
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licer	0 4	A 2	<ol><li>Name and Addr</li></ol>	ess of Facility Hic Stockton		e for	Funera	als, P		
			23a. Part1. Enter the disease, or com	plications that caused	I the death. Do not en						Approxima	ite	
1	Physician		shock, or heart failure. List only Immediate Cause (Final			. 12:					Interval Be Onset and		
1	Physician /Medical		disease or condition resulting in death)	a. End	Stace Repaire of:	nae uis	ease.				men	wn.	
ш	Examiner			200 10 (01 40	2 00/100 01/2								
	<u>-</u>	Jer.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):								
	The law requires that the death certificate be executed the has been signed by the attending physicien and oage 2 should be detached for use as the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	C									
Ó,	en an rial-tr	Ex	resulting in death) Last	Due to (or as	a consequence of):								
8760,	ite be iysici ne bu	cai		d									
9	ng ph as th		IF FEMALE:										
Вох	th ce	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth		⊒Ectopic pregnand	;y		23	3d. Date of deliment		Year	
	e dea	sici	1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown	time of death 5	Other (specify)				WORKI	Day	1001	
P.0	that the death certific ed by the attending p detached for use as	Physician/Me	9 Unknown				Desir Cont	22a Did t	<u></u>	e contribute to	the sause of	doesh?	
	ires tha signed d be dei	ā	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the t	inderlying cause g	ven in Part I.			ocontribute to No 3 □ Pro		Unknown	
oro	w requir been si should	ted						, ,	105 2	140 2011			
Records,	has b	Completed by						24a. Was autor	osy	24b. Were au	opsy findings ompletion of	available cause of	
H		ပ္ပ						1 ☐ Yes	rmed? 2 No	death? 1 ☐ Yes	2 🗆 No		
/ita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Managaria			26. Place of Death	(Check only o	ne)				
of Vital	Physicien: this certific ral director,	၉	1 Yes 2 No	Hospital: 1 ☐ Inpatie		nt 3 DOA	her: 4 Nursing Hor				ify)		
Ä	0 0 0	lon	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time ( y Year) Injury	W	ork?	28d. Describe I	now injury	occurred			
Sic	Attending r death. ector: After by the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b		unc - At home form of		]Yes 2□No	28f Location (	Street and	Number or Ru	ral Poute Nur	mber	
Division	or A after Directin by	Certification;	4 Homicide determined	building, et	ury - At home, farm, si c. (Specify)	root, raciony, onice	1	City or To		, sumber of Mu	LI FIGURE INUI		
_	To the Hospitel or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur		29a. Certifier 1 Certifying Ph	ysician: To the best	of my knowledge, dea	th occurred at the	ime, date and place	and due to the	cause(s) a	and manger as	stated.		
	Moi 24 h Fur etely	Medical	(Check only 2 Medical Examone)	niner: On the basis o and manner st	f examination and/or in	nvestigation, in my	opinion, death occurre	ed at the time,	date and	olace, and due	to the cause(	(s)	
	To th within To th	Me	29b. Signature and time of certifier	0 1113		29c. Licer	se number		29d. Date	signed (Month	, Day, Year)		

29d. Date signed (Month, Day, Year) 10.5.2012

State Registrar

Sachder -S. MD

29c. License number

29d. Date signed (Mo

10.5.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5. S SHCHDEV MD

126 A, E High ST EUK Ton MD 2/92/.

31. Date filed (Month, Day Year)

32. Registrar's Signature

33. Page 18 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiona

			for State Registrar	State of Maryle		tificate of L			Reg. No.	012	3360
П	Physicia	ın/	1. Decedent's Name (First, Middle, Last)					2. Date of De	ath	Year	3. Time of Death
-	Medic	cal	LaVerne Robinso  4a. Facility Name (if not institution, give str					Septemb			5:00 P M
	Examir	ier		,		4b. City, Town, or	Location of D	Death	4c. Cou	inty of Death Lnce Ge	orge's
	Funeral		1810 Jarvis Avenu  5. Social Security Number 6. Sex		rs. last birthday)	If Under 1 Year	If Under 24		th	g. Birthp	lace (State or Foreign
	Director		311 44 441	M 2 🗓 F	Yrs.	Months Days	Hours	Min. (Month, Da		Count	,,
	how at	٦	Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Loc	ation		April 1	.8, 195		DC Od. Inside City Limits
	anylar la-fsl	Director	Maryland   Prince Ge				Hill			"	1 X Yes 2 No
	or 28	į	10e. Street and Number	orge s		10f. Zip Code	LTTT		10g. Citizen	of What Count	try?
	s 23a nust b	Funeral	1810 Jarvis Avenu	e		20	745		Uni	ited St	ates
Maryland 21215-0036	e filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ρ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		Vas Decedent of Hi Yes, specify Cuba		? (Specify Yes or No- uerto Rican, etc.)		Race - America Black, White, e cify: Bla	tc.
5-0	2 hou "natu	plet	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	ent's Usual Occupa	ation during most of	workina	16b. Kind o	f Business/Ind	lustry
121	within 7 giene. er than	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do	O NOT use retired)			0		- de
d 2	filed within al Hygiene.	Be (	17. Father's Name (First, Middle, Last)	5+	Ke	gistered		Name (First, Middle,		vernmer	10
ılan	ould be fil nd Mental marked matic ev	Edward Robinson Beaunie Brooks									
lan	is at		19a. Informant's Name/Relationship (Type	, Print)	19b. Mailin	g Address (Street a	and Number o	r Rural Route Numbe	r, City or Towr	n, State, Zip Co	ode)
≥ 6	and 2: Health em 27 ther tr		John C. Bobo - Hus				venue	Oxon Hill,			.0745
Baltimore,	permit. Page 1 and Department of Hes Important: If item any injury or othe once,		20a. Method of Disposition  1 X Burial 2 Cremation 3 Re	emoval from State		atory or other plac		et. Date		on - City or Tov	•
ij	artme ortan injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Ft		In Cemete		2012   Stewart F			, Maryland Inc.
Ba	Depar Impor any in		Solm T. Stewn	#2 MO056				id NE Wasi			20019
J. Sec.	Physician/ Medical Examiner	r	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one dimmediate Cause (Final disease or condition resulting in death)	ations that caused the decause on each line.  Lung Car  Due to (or as a conse	ncer	r the mode of dying	g, such as can	diac or respiratory arr	rest,		Approximate Interval Between Onset and Death
09	ath certificate be executed attending physician and for use as the burial-transit	Aedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse							
). Box 68760	The law requires that the death certificate be executed attends been signed by the attending physician and page 2 should be detached for use as the burial-trans	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown	c. If yes, outcome of prec 1  Live Birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3	Ectopic pregnanc Other (specify)	у			Date of deliver Month [	'Y Day Year
ds, P.O.	requires that been signed t should be det	by	Part II. Other significant conditions contr	ibuting to death but not	resulting in the u	nderlying cause giv	en in Part 1.				e cause of death?
Division of Vital Records,	Physician: The law re r this certificate has be eral director, page 2 sh	Completed						24a. Was a autop perfor 1 ☐ Yes	rmed?	b. Were autops prior to com death? 1 \( \sum \text{Yes} \) 2	sy findings available inpletion of cause of
ita	ician certifi rector	m	25. Was case referred to medical examiner?  1  Yes 2 No	spital:		Othe	ur*	Check only one)			
∑ _<	r this eral di	e: 1	27. Manner of Death	1 Inpatient 2 28a. Date of injury	ER/Outpatien 28b. Time of	28c. Injury	4 ∐ Nursir	ng Home 5 🖺 Resid			
n	nding ath. r: Afte re fun	icat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work'			ow injury occi	arred	
Divisio	al or Atte s after dea Il Director ed in by th	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		et, factory, office		28f. Location (S City or Tow		nber or Rural F	Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical	29a. Certifier 1 XCertifying Physicia (Check 2 Medical Examiner only one) 3 Certifying Nurse F	an: To the best of my kno On the basis of examina Practitioner: To the best of	tion and/or investi	gation, in my opinio	n, death occur	red at the time, date ar	nd place, and	due to the caus	se(s) and manner stated
	To t To t		29b. Signature and title of certifier			29c. License	number		29d. Date sign	ned (Month, Da	ay, Year)
	2		AV	06			6665		Octobe	r 1, 2	012
	3500		30. Name and address of person who com				90 T	orgo Marri	1222 2	077/	
	Stat		Dona M. Leskuski I 31. Date filed (Month, Day, Year)	MD 1801 Mc		Drive #1	ου <b>,</b> Ε	argo, Mary	rand 2	.0774	

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Eileen Patricia Rocchio Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days (Month, Day, Year) 214-44-5004 Hours Director 1 □ M 2 🛛 F 68 MD 06/09/1944 ie 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f shor or other traumatic event, the Medical Examiner must be notified at. 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Sykesville 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 104 Heritage In. 21784 **USA**  Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married Black, White, etc. þ Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify. Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) assembler Northrop Grumman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Joseph Pursel Gertrude Margaret McAuliffe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Anthony Rocchio/husband Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If ii any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll 10/10/2012 Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facture Funeral Home and Chapel myk No 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEP Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner NEUTROPENIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): sician and burial-transit CHEMOTHERAS or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ng physician a as the burial NON SMALL CELL METASTATIC Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregna 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death is certificate has been signed by the a director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by YOCARDIAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Was an this certificate has autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \subseteq \text{Other (Specify)} 1 ☐ Yes 2 ☑ No ၉ To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this c completely filled in by the funeral dir 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10-9-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 MEMORIAL State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Month DONALD RAY STALEY SR 5:10PM Medical SEPTEMBER 28, 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8 Date of Birth Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) (Month, Day, Year) 03/03/1938 214-42-5467 Director 1 M 2 □ F 74 MD Usual Residence of Decedent 10a. State 10b. County within 72 hours after death with the Maryland ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director FREDERICK FREDERICK 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21703 6404 WEATHERBY COURT, #C 12. Was Decedent Eyer in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 Ø No Specify. 3 Widowed 4 Divorced Specify: WHTTE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) DAIRY FARMER FARMING 12 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any Injury or other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname)
NELLIE CLAGGETT 17. Father's Name (First, Middle, Last) RALPH FLEET STALEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10411 WHITEROSE DR., NEW MARKET, MD 21774 SON DONALD STALEY, JR. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removal from State BOYDS CEMETERY 10/03/2012 BOYDS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fone al Savir e Licensee 22. Name and Address of Facility P.O. BOX 86 HM HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONI Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a nonsequence of) or Attending Physician: The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Dther (specify) Month Day Year a | Unknown g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PA M 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed 1 ☐ Yes 2 ☐ No Yes 2 X No To the Hospital or Attending Physician: I within 24 hours after death.
To the Funeral Director: After this certifica completely filled in by the funeral director; t 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The Gertifying Projection in the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the F only one) 29b. Signature and title of certifier 58808 10/01/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month 32. Registrar's Signature State Registrar

			Pleas	State of M							-		_	ie.		
			For State Registrar	State of ivi	laryland / D	•	artmen <i>tificat</i> e			anu iv	¹entai ⊓y	giene Reg. No	20	12	336	504
	Diam'i ai		Decedent's Name (First, Middle, L.)	.ast)			timode	J C	700		2. Date of De	ath	o. <u>L.</u> O	<u> </u>	3. Time of D	
	Physicia Medic		Shirley Jea		t						Septem				6:50	Ам
Jane 1	Examin	ier	4a. Facility Name (if not institution, g. Frederick Mem		ital			Town, or	Location of	of Death	4c. County of Death Frederick					
<u> </u>	Funeral		Social Security Number 6.		ge (In yrs. last birth	iday)	If Under Months		If Under Hours	24 Hrs. Min,	8. Date of Bir (Month, Da	th Vear	9	Birthpl	lace (State or F	Foreign
	Director		003-24-7586 Usual Residence of Decedent	1 □ M 2 🗓 F	78 <sub>Y</sub>	Yrs.	IVIOLITIS	Days	Hours	IVIIII,	June 19		34 N		u Hampshi	re
	show	tor	10a. State 10b. County		10c. City, Town	or Loc	cation					*		10	Od. Inside City	Limits
	Mary 28a-f	irec	Maryland Freder	ick	Walke	ers									1 X Yes 2	2 □ No
	ith the	Funeral Director	10e. Street and Number 105 Sandstone D	- / # 210			10f. Zip	.793			1.	_	itizen of Wha		-	
	eath w	une	11. Manital Status	12. Was Decedent	Ever in U.S.	13. V	Nas Deced	dent of His	spanic Ori	gin? (Spe	cify Yes or No-		ed St			-
98	fter de		1 Never Married 2 Married	Armed Forces?  d 1 ☐ Yes 2 ☒  If Yes, Give	No	If	f Yes, spec I ☐ Yes	ify Cubar	n, Mexicar	n, Puerto	Rican, etc.)		Black,	White, e	tc.	
Ö	ours a atural	eted	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.  15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business													
21215-0036	within 72 hours after death with the Maryland glene er then "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at t.	Completed by	15. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) (Give kind of work done during most of working life. DO NOT use retired)											ustry		
21	J within ygiene ther th	Be Co	Elementary/Secondary (0-12)			cos	sing	Guar					Safet	у		
Maryland	l be filed v tental Hyg rked othe	10 B	17. Father's Name (First, Middle, Last)  Ralph Hartshorn  18. Mother's Name (First, Middle, Maiden Surname)  Doris Chamberlin													
aryl	should be file and Mental F 7 Is marked o raumatic eve		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2										e, Zip C	ode)		
	je 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hyglene. It of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show if item 27 is marked other than "natural", or items 25a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Laurel Marrs - daughter 104 Crossbill Way, Frederick, Maryland											1702		
Baltimore,	ge 1 ar t of H i. if itel or oth		20a. Method of Disposition 1   Burial 2 ☐ Cremation 3		20b. Place of cemetery	y, crem	natory or o	ther place	e)		Date		ocation - Ci	-		
ltir	permit. Page 1 a Department of I Important: If ite any injury or ot		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lice		Restha						9-2012				lary1an	d
Ba	Depi Imp		21. Signature of Funeral Service Microsoft Facility Stauffer Funeral Home 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland											land	21702	
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									<u> </u>		Approximate Interval Betwe				
	Immediate Cause (Final disease or condition					20	are	10	om	a					Onset and De	
	Medical Examiner		resulting in death)	Due to (or as	a conseque ce o	h:		Callery III	William Con							
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of	f):										
	be executed sician end burial-transit	Examiner	that initiated events	C. Dura to for an		3.								1		
	be exe ician e burial-	alE	resulting in death) Last	` .	a consequence of	ŋ:										
3760	ficate t g phys	ledic		<b>d</b>		_								$\pm$		
Box 6876	h certii tending r use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	of pregnancy 2  Fetal death	3 □	Ectopic r	pregnanc <sup>i</sup>	v			-	23d. Date of	of delive	ry	ļ
Bo	Attending Physician: The law requires that the death certificate be executed at death.  **rdeath.** **ector.**Alert this certificate has been signed by the attending physician end by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Medi	1 Yes 2 No 9 Unknown		at time of death		Other (sp						Month	[	Day Yea	ar
P.0.	that the	by Ph	Part II. Other significant conditions	contributing to death t	but not resulting in	the u	nderlying	cause giv	en in Part	I.	23e. Did t	obacco	use contribu	te to the	e cause of dea	ıth?
ds,	quires t	ed p									1 🗆	Yes 2	□ No 3	☐ Prob	ably 4 Un	nknown
Cor	law rec has bee ge 2 sho	Completed									24a. Was		prio	r to com	sy findings ava	ailable use of
Be	ilcian: The la certificate ha rector, page										1 🗌 Yes	ormed)	dea 1	th? Yes 2	2 🗆 No	
/ital	rsician s certif directo	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	ient 2 🗆 ER/Out	tootion	<u> </u>	Otho	ce of Dea				. [] ou			-
of o	ng Phy ter this meral o		27. Manner of Death 1  Natural 5 □ Pending	28a. Date of inju	ury 28b. Ti			8c. Injury	at		me 5 🗌 Resid 28d. Describe f	_		<i>эреспу)</i>		
ion	tendir Jeath, tor: Af the fu	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigat 3 ☐ Suicide 6 ☐ Could no	tion		-4	М	1 🗆 ነ	Yes 2	_				-		
Division of Vital Records,	To the Hospital or Attending Physiciam: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director.	Seri	4 Homícide determine		jury - At home, fam c. <i>(Specify)</i>	m, stre	et, factory	, office			28f. Location (\$ City or Tov			r Rural f	Route Number,	;
<b>.</b>	Hospital or 24 hours afte Funeral Din tely filled in	Medical	29a. Certifier 1 Certifying P	hysician: To the best of	f my knowledge, d	leath c	occurred a	t the time	, date and	place, ar	nd due to the ca	ause(s) a	and manner	as state	d.	
	To the H within 24 To the Fi complete	Me	only one) 3 L Certifying N	uminer: On the basis of e urse Practitioner: To th	ne best of my know	ledge,	death occ	urred at th	ne time, da	te and pla	the time, date a ice, and due to t	the cause	e(s) and man	ner as st	ated.	er stated.
	<b>5 ≥ 5</b> §		29b. Signature and title of certifier	Buch	mi		290	. License	number	71/		29d. Da	ite sign <b>ed</b> (A	/		1.5
	10		30. Name and address of person wh	o completed cause of c	death (Item 23a) (T	ype, P	rint)	20	0 10	24			_//	-4	1702	12_
	$\overline{v}$		Eric Bush	m),	5167	ro	1 1	AV	e,	Fre	deric	K	m	2	1702	>
	Stat		31. Date filed (Month, Day, Year)	2012 32. Registra	ar's Signature	15	arke	/				,				

(Check 2 L. Medical Ex	complications that cause compact live in the cause on each live in the cause of live	sed the death ine.  Is a consequence of pregnant 2   Fetal at time of death at time of deat	22 1 1. Do not enterence of):  ence of):  ence of):  ence of):  ence of):  extraction of the unit of t	Ectopic pregnan Other (specify)  26. P  28. Injunyor  M  28. Injunyor  t, factory, office	ess of Facility B  Liam St  ng, such as cardia  (  cy  ven in Part I.  lace of Death (Che er: 4 Nureing) y at y at Yes 2 \(  No  n, date and place, on, death occurred on, death occurred	23e. Did to 1 24a. Was a autop perfor 1 Yes  2ck only one)  28f. Location (S City or Town  28f. Location (S autop or Town)  28f. Location (S autop or Town)	Funer est,  23d.  bacco use co fes 2 \( \text{N} \)  win sy med? 2 \( \text{X} \)  bow injury occ  treet and Nur n, State)	Date of de Month  Date of de Month  Ontribute to death?  1   Yes  Other (Specurred	Approximate Interval Better Number of the cause of de probably 4 1 No strong from the cause of de probably 4 1 No strong from the cause of de probably 4 1 No strong from the cause of de probably 4 1 No strong from the cause of de probably 4 1 No strong from the cause of de probably 4 1 No strong from the cause of de probably 4 1 No strong from the cause of de probably 4 1 No strong from the cause of de probably 4 1 No strong from the cause of de probably 4 1 No strong from the cause of de probable of	ar ar ailable use of
A. Part 1. Enter the disease, or a shock, or heart failure. List or mediate Cause (Final sease or condition sulting in death)  In a condition sulting in the condition sulting in death)  In a condition sulting in the condition sulting in death)  In a condition sulting in the condition sulting in death)  In a condition sulting in the condition sulting in death) Last  In the past 12 months?  I wes 2 No 9 Unknown  It II. Other significant condition to the condition sulting in death sulting in death sulting in death sulting in death sulting in the past 12 months?  I wes 2 No 9 Unknown  It II. Other significant condition sulting in death sulting in death sulting in death sulting in the condition sulting in the past 12 months?  I was case referred to medical examiner?  I was case referred to medical examiner?	complications that caus only one cause opeach list.  a. Due to (or a d. Due to	is a consequence of pregnan 2  Fetal at time of definition of the state of the stat	22 1 Do not enterence of):  ence of):  ence of):  liting in the uncertain injury  ne, farm, streen	Dame and Address of Swill are the mode of cyling cause given by the state of the st	ess of Facility B  Liam St  ng, such as cardia  (  cy  ven in Part I.  lace of Death (Che er:	23e. Did to 1 24a. Was a autoporto de control de contro	Funer est,  23d.  bacco use co fes 2 No	Date of de Month  Ontribute to o 3 Peb. Were au prior to death? 1 Yes	Approximate Interval Betwoonset and D. C. J. W. J. J. W. J.	1 eeen eath
a. Part 1. Enter the disease, or a shock, or heart failure. List or mediate Cause (Final sease or condition sulting in death)  equentially list conditions, and, leading to immediate use. Enter Underlying use (Disease or injury at initiated events sulting in death) Last  EMALE:  . Was decedent pregnant in the past 12 months?  1	complications that caus only one cause opeach list.  a. Due to (or a d.)  Due to (or a d.)  23c. If yes, outcom 1  Live Birth 4  Pregnant 9  Unknown as contributing to death	is a consequence of pregnan 2  Fetal at time of de	22 1 Do not enterence of):  ence of):  cry death 3 = eath 5 = eath 5	Name and Address  O 8 Wil  or the mode of dyi  Ectopic pregnan Other (specify)  nderlying cause gi	ess of Facility B  liam St  ng, such as cardia  (  cy  ven in Part I.	urbage reet, B c or respiratory arr  1 - Lucu  23e. Did to 1   1   1   24a. Was a autop perfor 1   1   Yes eck only one)	Funer erlir est,  23d.  bacco use co fes 2 \( \sigma \) No.	Date of de Month  Ontribute to 3 Prib. Were au prior to death?	Approximate Interval Better Onset and Downst	1 eeen eath
a. Part 1. Enter the disease, or a shock, or heart failure. List or mediate Cause (Final sease or condition sulting in death)  equentially list conditions, and, is admit to immediate use. Enter Underlying use (Disease or imjury at initiated events sulting in death) Last  EMALE:  b. Was decedent pregnant in the past 12 months?  1	complications that cause on each live one cause on each live of a cause on each live one cause on each live on each liv	is a consequence of pregnan 2  Fetal at time of de	22 1 Do not enterence of):  ence of):  ence of):	Name and Address  O 8 Wil  or the mode of dyi  Ectopic pregnan Other (specify)  nderlying cause gi	ess of Facility B Liam St ng, such as cardia	urbage reet, B c or respiratory arr  1 - Luce  23e. Did to 1 - N  24a. Was a autop 1 - Yes	Funer est,  23d.  bacco use or fees 2 \( \sim \) No sy med?	Date of de Month  Date of de Month  Date of de Month	Approximate Interval Betwoonset and D. C. J. W. J. J. W. W. J. W.	1 eeen eath
a. Part 1. Enter the disease, or a shock, or heart failure. List or mediate Cause (Final sease or condition sulting in death)  squentially list conditions, and, leading to immediate use. Enter Underlying use (Disease or injury at initiated events sulting in death) Last  EMALE:  b. Was decedent pregnant in the past 12 months?  1	complications that cause on each live one cause on each live of a cause on each live one cause on each live on each liv	is a consequence of pregnan 2  Fetal at time of de	22 1 Do not enterence of):  ence of):  ence of):	Name and Addre	ess of Facility B liam St ng, such as cardia	urbage reet, B c or respiratory arr	Funer est,  23d.  bacco use co	Date of de Month	Approximate Interval Better Onset Better Onset Better Onset and Declared Property of the cause of decrobably 4 🛣 U	een eath
a. Part 1. Enter the disease, or a shock, or heart failure. List or mediate Cause (Final sease or condition sulting in death)  squentially list conditions, and, leading to immediate use. Enter Underlying use (Disease or injury at initiated events sulting in death) Last  EMALE:  b. Was decedent pregnant in the past 12 months?  1	complications that cause on each live one cause on each live of a cause on each live one cause on each live on each liv	is a consequence of pregnan 2  Fetal at time of de	22 1 Do not enterence of):  ence of):  ence of):	Name and Addre	ess of Facility B liam St ng, such as cardia	urbage reet, B c or respiratory arr	Funer erlir est,	Cal F	Approximate Interval Better Onset and Discourse and Discourse Interval Better Onset and Discourse Interval Better Onset and Discourse Interval Better Onset Interval Better Description Better Onset Interval Better Onset Interval Better Onset Interval Better Description Better Onset Interval Better Description B	1 een eath
a. Part 1. Enter the disease, or a shock, or heart failure. List or mediate Cause (Final sease or condition sulting in death)  requentially list conditions, and, leading to immediate use. Enter Underlying use (Disease or iinjury at initiated events sulting in death) Last  EMALE:  . Was decedent pregnant in the past 12 months?  1	complications that caus ally one cause op each list a.  Due to (or a.)	sed the death ine.	22 1 Do not enterence of):	. Name and Addre	ess of Facility B liam St ng, such as cardia	urbage reet, B	Funer erlir	Cal i	Approximate Interval Betwoonset and D	1 een eaath
a. Part 1. Enter the disease, or shock, or heart failure. List or mediate Cause (Final sease or condition sulting in death)  requentially list conditions, any, leading to immediate use. Enter Underlying use (Disease or linjury at initiated events	complications that cause and one cause on each life.	sed the death ine.	Do not ente	Name and Addre	ess of Facility B Liam St	urbage reet, B	Funer	cal i	Approximate Interval Betwonset and D	1 een eath
a. Part 1. Enter the disease, or o shock, or heart failure. List or mediate Cause (Final sease or condition sulting in death)	consee Aloc complications that caus nly one cause on each li a. Due to () a	sed the death ine.	Do not ente	Name and Addre	ess of Facility B Liam St	urbage reet, B	Funer	cal i	Approximate Interval Betwonset and D	1 een eath
Sign was of Fuñeral Service by a. Part 1. Enter the disease, or o shock, or heart failure. List or mediate Cause (Final sease or condition	complications that cause on each li	sed the death ine.	Do not ente	Name and Addre	ess of Facility B Liam St	urbage reet, B	Funer	cal i	IOINE  Approximate Interval Betwoen Conset and D	1 een
Sign your of Funeral Service by	ac Loc		22	Name and Addre	ess of Facility B Liam St	urbage reet, B	Funer	cal i	Tome 2. 2181	1
		FI								•
T - Dana - Z - Coromation	if-i	m:					2 4 20 7	11060	oro, De	
a. Method of Disposition		20b. Pl	ace of Dispo		ce)	Date	20c. Location		ZISII	
a. Informant's Name/Relationshi	ip (Type, Print)		19b. Mailin		and Number or R	ural Route Numbe	r, City or Tow	n, State, Zi		
		p. Sr			1		Maiden Surn	ame)		
	st grade completed)	or 5+)	(Give I life. D	kind of work done O NOT use retired	during most of wo )	orking				
3 ☐Wildowed 4 ☐ Divorced	If Yes, Give Year or Dates.	. No								_
Marital Status	12. Was Deceden	nt Ever in U.S	i. 13. V	Vas Decedent of I f Yes, specify Cub				Race - Ame	erican Indian,	
e. Street and Number				10f. Zip Code	21211		10g. Citizen		ountry?	
a. State 10b. County WD.	rcester	1 - 1								
213-30-6794 ual Residence of Decedent	1 <del>Q</del> M 2 □ F	7	9 Yrs.	Months Days	Hours Mir	0 6 - 22-	-1933	Co	ountry)	
	6. Sex 7. /		ast birthday)	If Under 1 Year	If Under 24 Hr		th	9. Bi	rthplace (State o.	Fore
Facility Name (if not institution,	give street and number	r)	r.	4b. City, Town,	or Location of Dea					P
Decedent's Name (First, Middle,					-			Year		
7 1 1 3 a 7	State Registrar #26, pe Decedent's Name (First, Middle Clarence Wi Facility Name (if not institution, Atlantic General Cocial Security Number Clarence of Decedent State 10b. County Wi Mi Street and Number 401 Yacht C. Marital Status 1 Never Married 2 Marria 3 Widowed 4 Divorced (Specify only higher Elementary/Seconday (0-12) Father's Name (First, Middle, Li Clarence Will A. Informant's Name/Relationsh andra P. Sha	Registrar #26, per phys.,10.  Decedent's Name (First, Middle, Last)  Clarence William Sha Facility Name (if not institution, give street and number.  Atlantic General Hosp  Cocial Security Number  Clarence William Sha Facility Name (if not institution, give street and number.  Atlantic General Hosp  G. Sex  1	Clarence William Sharp, Clarence Worcester  Marital State  Morcester  Marital Status  Morcester  Morcester  Marital Status  Morcester  Morc	Registrar #26, per phys., 10/3/12, Cel Decedent's Name (First, Middle, Last)  Clarence William Sharp, Jr. Facility Name (if not institution, give street and number)  Atlantic General Hospital  Social Security Number 6. Sex 7. Age (In yrs. last birthday)  13-30-6794 1 M 2 F 7. Age (In yrs. last birthday)  13-30-6794 1 M 2 F 7. Age (In yrs. last birthday)  10c. City, Town or Lot  10b. County 10c. City, Town or Lot  10b. County 10c. City, Town or Lot  10c. City	Registrar #26, per phys.,10/3/12, Certificate of Decedent's Name (First, Middle, Last)  Clarence William Sharp, Jr. Facility Name (if not institution, give street and number)  Atlantic General Hospital  Cocial Security Number  Clarence Formula Hospital  Cocial Security Number  Cocial Security Number	Clarence William Sharp, Jr.   Facility Name (if not institution, give street and number)   Ab. City, Town, or Location of Dec Atlantic General Hospital   Berlin	Comparison of the content of the c	Registrar #26, per phys.,10/3/12, Certificate of Death WCHD, E.T. Reg. No. Decedent's Name (First, Middle, Last)  Clarence William Sharp, Jr.  Facility Name (if not institution, give street and number)  Atlantic General Hospital  Colai Security Number  1.3 - 30 - 6.79.4  1.2 M 2   F. Age (In yrs. last birthday)  1.3 Late   10b. County   10c. City, Town or Location   10d. City, Town or Location	Registrar #26, per phys., 10/3/12, Certificate of Death WCHD, E.T. Reg. No.  Decedent's Name (First, Middle, Last)  Clarence William Sharp, Jr.  Facility Name (if not institution, give street and number)  Atlantic General Hospital  Cocial Security Number  Clarence William Sharp, Jr.  4b. City, Town, or Location of Death  Berlin  Berlin  Cocial Security Number  Clarence William Sharp, Jr.  Application of Death  Berlin  Cocial Security Number  Cocial Security	Register   1/20   Pet   Phys., 10/3/12   Certificate of Death WCFI)   E.T.   Reg. No.

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Schaub Harriett S. toBe Medical 4c. CeOnty of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1-NICAL If Under 1 Year If Under 24 Hrs. 8 Date of Birth g. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9/24/1921 Maryland Day Min 91 216-12-7941 Director 1 🗆 M 2 🗗 🗱 Usual Residence of Deceden 10d. Inside City Limits 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No PA York Delta 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 17314 584 Kilgore Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ♣ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married δ Specifywhite 1 ☐ Yes 2X No 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) bwn home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Doris Rau Albert Thursby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 584 Kilgore Road, Delta, PA 17314 M. Terry Schaub- son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Eagle Crematory 10/8/ 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 🛭 emation 3 ☐ Removal from State 12 Leola,P 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral ervice Lic 22. Name and Address of Facility Harkins F.H.Inc., Delta, PA 17314 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 V No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≥</u> 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဂ္ 1 Yes 1 Nopatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No 1 Matural Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: Jethe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 21 ne and address of person who comp of death (Item 23a) (Type, Print) SLER 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 30. 2012 Jane K. Thomas 5:15 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington NMS Healthcare Hagerstown If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Hours March 29 °ATabama 84 Director 417-34-6800 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Washington Hagerstown 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a omnust be Funeral 21742 United States 14014 Marsh Pike Was Decedent Ever in U.S. Armed Forces 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 2 X No 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates Health and Mental Hygiene. em 27 is marked other than "natu ther traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Buna Allgood Clarence R. Keener 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 750 Carroll Parkway, Apt. 8E, Frederick, MD 21701 Department of Health Important: If item 27 any injury or other th Harvey Lee Thomas, Jr./Son 20a. Method of Disposition
1 □ Burial 2 X Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 2, cemetery, crematory or other place) 4 Donation 5 Other (Specify) Smithsburg Crematory 2012 Smithsburg, Maryland e of Funeral Service Licen KeeneydandssBastord PA Funeral Home, M01473 106 E. Church Street, Frederick, Maryland 21701 complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest tonly one cause on each line. 23a. Ravt 1. Enter the disease, shock, or heart failure. Light )15CGSC Immediate Cause (Final ALTECL Onset and Death Physician/ 10000acu disease or condition resulting in death) Medical Examiner Demen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner -transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pendina 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R125

Registrar DHMH 17 Rev 7/2009

State

P.O. Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 09 Physician/ 2012 5:54AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** aroline Denton rsing . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 Months Days Hours Min. 12-26-1917 Mississippi Director 215-20-4654 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director Md. Caroline 1 Yes 2 No Denton 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I Funeral 910A Gay Street USA 21629 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Farming Farmhand Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Estetta Harris Eddie Seymour 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Dickerson/Daughter Α Davis Ln., Federalsburg, Md. 21632 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 10-06-12 Denton, Maryland Grove Cem! Signature of Funeral Service License 22. Name and Address of Facility 22. Name and Address of Pacifity
Bennie Smith Funeral Home
Easton, Md, 21601 Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ eime disease or condition Medical resulting in death) Due to (or us a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial Physician/Medical Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death ed by the a detached f g Unknown 9 Unknown Division of Vital Records, P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate | 2 P N 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 1 No Other: ည 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Aursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Atural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Ho.
in 24 hour.
io the Funeral Diccompleted fille Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. 36 252 enton

State Registrar strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2012 Dorothy Lannette Tesch 0147 A<sub>M</sub> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Ceci1 Union Hospital E1kton Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days 1 - M 2 X March 5, Year 936 West Virginia 218-32-7254 Director 76 Usual Residence of Decedent 10b. County lid be filed within 72 hours after death with the Maryland Mental Hygiene.

Mental Hygiene.

Jarked of the than "natural", or items 23a or 28a-f show airce event, the Medical Examiner must be notified at aftic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland Ceci1 E1kton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1032 Elk Forest Road 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 ☐ Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker In Her Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed.
Department of Health and Mental H
Important: If item 27 is marked ot
any injury or other traumatic even ည George Vance Dolly Newberry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry McMullen/Daughter 139 Milestone Road, Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State October 8. 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co., Inc. 2012 West Chester, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part Nenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 🗙 No 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural work? 1 ☐ Yes 2 ☐ No. 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0062190 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHNAWAZ KHAN MI)

State Registrar 31. Date filed (Mo

, SUITE A , CHESAPEAKE CITY,

HERMAN HWY

INE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Wilson -orraine Physician/ Month 09 2012 2:32 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charles County Nursing & Rehab Cntr. La Plata Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Min Hours Director 141-20-9779 1 □ M 2**X** F 12-16-1930 Usual Residence of Decedent New Jersey filed within 72 hours arrow ital Hygiene.
ed other than "natural", or items 23a or 28a-f show ed other than "hatural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 Yes 2 No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10425 Starlight Place 20603 United States Was Deceden.
Armed Forces?
Yes 2 No 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. Specify: 3 Widowed 4 XDivorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Customer Service Communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Hitem 27 is marked of မ Henry Wilson Mary Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Marshall/Cousin 10425 Starlight Place Waldorf, Maryland 20603 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State jo. Department of Important: If it any injury or o 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) Brinsfield-Echols 10-02-2012 | Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Li 22. Name and Address of FacilityArehart-Echols Funeral Home, P.A. M01458 Box 567 La Plata, Maryland 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence the attending physician Physician/Medical Box 68760 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Unknown P.O. þ 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s performe 2 No 1 Yes Division of Vital 25. Was case referred filled in by the funeral director, 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier ပ္ 10/02/2012 30. Name and address of person who completed captle of death (Item 23a) (Type, Print) ation Blud, SteB, Glen Bwine, MO, 2106)
DETOSIN VAZ happilly, 6934 Aviation Blud, SteB, Glen Bwine, MO, 2106)

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Septh. 29. Day 2012 Year Thomas Wilson 10:05pм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Casey House/Montgomery Hospice Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Days Hours 219-48-1942 Director 1 ፟፟M 2 □ F 65 Apr.17,1947 Virginia Usual Residence of Deceder should be filed within 72 nouse and and Mental Hygiene.
I is marked other than "nature!", or items 23a or 28e-f show a marked other than "nature!" and item must be notified at 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Rockville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7008 Sulky Lane Funeral 20852 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No If Yes, Give Year or Dates. Army 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 I No Specify: White Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) W.S. Post Office Postal Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norton B. Wilson Marion Hunter .. Page 1 end 2 should be tment of Health and Men tant: if item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Megan E. Wilson / Daughter 819 S.Oldham St., Baltimore, MD 21224 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20c. Location - City or Town, State Department of H Important: if ite any Injury or ot Date 1 Burial 2 Dremation 3 Removal from State 10/01/2012 Baltimore, MD 4 Donation 5 Other (Specify) 21. Symbol Furneral Service 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 en 23a. Part 1. Enter the disease shock, or heart failure. Ust omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Prostate Cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed anding physician end use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attanding physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? 5 Other (specify) 1 Yes 2 No Pregnant at time of death page 2 should be detached g Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate hes autopsy performed? Yes 2 A No death? 1 🗌 Yes 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 H Other (Specify) Hospice မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 A Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

6001 Muncaster Mill

31. Date filed (Moetto Day, Verd 2012

Road

32 Registrar's Signatu

DHMH 17 Rev 06-2011

MD 20855

Debrah Miller CRNP

Rockville,

Examiner 4b. City, Town, or Location of Death 211 Emilys Way Davidsonville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 578-58-4025 Director 1 X M 2 🗆 F Usual Residence of Decede 28a-f show 10a. State 10c. City, Town or Location by Funeral Director ms 23a or 28a-f sh must be notified a MD Anne Arundel Davidsonville 10e. Street and Numbe 10f. Zip Code 211 Emilys Way 21035 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No 11. Marital Status r than "natural", or ite the Medical Examiner 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. If Yes Give Year or Dates. Navy 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Master Plumber Be 17. Father's Name (First, Middle, Last) 27 is marked or traumatic eve ပ Allen Armstrong Worrell 19a. Informant's Name/Relationship (Type, Print) Jennifer J. Worrell/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) VeteransCem. of Fineral Service Licensee or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Sepsis Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or Injury that initiated events resulting in death) Last as the burial-tran and Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 9 Unknown the Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ End Stage Renal Disease Records, Completed Coronary Artery Disease has Diabetes Mellitus 25. Was case referred to medical Division of Vital Certificate: To Be examiner? X 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at s after death. 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier only one) 29b. Signature and tite of certifier 29c. License number D45660 4+1

1 - For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Robert Allen Worrell 2012 ear Sept.26,  $1:43p^{M}$ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Anne Arundel Birthplace (State or Foreign Country) 8. Date of Birth May14,1947 Washington, D.C. 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Plumbing 18. Mother's Name (First, Middle, Maiden Surname) Lorraine Butler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 Emilys Way,Davidsonville,MD 21035 20c. Location - City or Town, State 10/04/2012 Cheltenham, MD 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate nterval Between Onset and Death 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 No 26. Place of Death (Check only one) 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) September 27,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 Gallant Fox Lane, #124, Bowie, MD 20715 Dr. Dpinder Singh 31. Date filed (Month, Day, Year) OCT 02 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PI line c per MD G942 8/28/13 TRT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 33614 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 24, 2012 3:57 A M Barbara Lee Wist Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 5. Social Security Number 217-58-4920 9. Birthplace (State or Foreign Director 1 M 2 T F 64 10/12/1947 Virginia 28a-f show ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 🗆 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2700 South Haven Road USA 21401 filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Charles Richard Jessup Mildred Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 91 Summerhill Park, Crownsville, MD 21032 permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Tobi Rodevick - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place)
Hillcrest Memorial Gardens Annapolis, MD Signature of Funeral Service 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucetser St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph\_sician/ Onset and Death disease or condition Medical resulting in death) as a consequence of): Examiner Sequentially list conditions, if any reducing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequency of Exami Pancreatitis and resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the attending ph d for use as th IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was an autopsy performed? has this certificate Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 Supportient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c, Injury at work? 1 Yes 2 No Certificate: 28b. Time of 1 Natural 28d. Describe how injury occurred 5 Pending injury within 24 hours after death To the Funeral Director. Р сотрletely filled in by the f Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) Pype, Print) 3 \_Joseph-Herbert State OCT 02 2012 Registrar

27#7B

	_ For	State of Ma				ı <b>k. Ens</b> u Health a				_		0001
	State Registrar			Cert	tificate of	Death			Reg. No	. ZU	1 4	3361
ian/	1. Decedent's Name (First, Middle, Las	enry Willi	2mc					2. Date of Dea Month eptemb		) 6 2 Ye	ear	3. Time of Death 12:45 A M
ical ner	4a. Facility Name (if not institution, give		ans		4b. City, Town, o	or Location of		ерсешь		. County of I		12:45 A <sup>M</sup>
	Heartland of Hya					Hyati		le	]	Prince	e Ge	eorge's
	5. Social Security Number 6. Social Security Number 1		(In yrs. last	"	If Under 1 Year Months Days		Min.	Date of Birt (Month, Day		9	. Birthp	olace (State or Foreigr try)
	Usual Residence of Decedent	× M 2 □ F   7	7	Yrs.			F	eb. 23	, 19	935 M	lary	land
ctor	10a. State 10b. County		10c. City, T	own or Loca	ation		,,	• 1 1 -			1	0d. Inside City Limits
Director	Maryland Prince G	eorge's			Hyattsvil							
	6500 Riggs Road		20783						-	tizen of Wha J <b>nited</b>		-
uncia	11. Marital Status	12. Was Decedent Ev Armed Forces?	Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-						Ť	14. Race - /		
Completed by	1 Never Married 2 X Married 3 Widowed 4 Divorced	1 X Yes 2 1 N If Yes, Give Year or Dates.	No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1  Yes 2 No Specify:					Black, White, etc. Specify: Black			
	15. Decedent's E (Specify only highest gra	de completed)	Give kind of work done during most of working						16b. K	ind of Busin	ess/Ind	dustry
	Elementary/Secondary (0-12)	College (1-4 or 5-	+)	life. DO NOT use retired) Bricklayer					Privat			
To Be	17. Father's Name (First, Middle, Last)	.t. T 1731'	1 4			18. Mother		irst, Middle, i		Surname)		
	19a. Informant's Name/Relationship (Ty	oh Leo Wili				<u> </u>		nor De				
	Barbara Williams		1		Address <i>(Street</i> Eastern							
	20a. Method of Disposition	_	20b. Place	e of Disposi	ition (Name of atory or other pla		Dat			ocation - Cit		
	1 🔀 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State y)	J		10ry or other pla	tery	ct. 5	12	Br	entwo	od,	Maryland
	21. Signature of Funeral Service Licens	A			Name and Addre			wart F				
-	23a. Part 1. Enter the disease, or comp	M	00560		001 Benn					ton,	DC	20019
	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Cardio Respiratory Arrest  Due to (or as a consequence of):											Approximate Interval Between Onset and Death
_	Sequentially list conditions, if any, leading to immediate  b. Acute Myocardial Infarction  Due to (or as a consequence of):											
xamıner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2	D.									
Exa	that initiated events resulting in death) Last	c. Atheros		ardiova	scular	Dise	ease			+		
Med	JF FEMALE:											
	23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome o 1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Fetal de	eath 3 🗌	3  Ectopic pregnancy 5 Other (specify)				23d. Date of deliv			ory Day Year
	Part II. Other significant conditions co	ontributing to death bu	t not resultir	ng in the und	derlying cause gi	ven in Part I.		23e. Did to	bacco u	se contribut	e to th	e cause of death?
ב ב	Hypertension							1 □ Y	es 2[	□ No 3 🛭	¥ Prob	ably 4 🗆 Unknown
	Peripheral Vascul	Lar Disease	2					24a. Was a		24b. Were	autop	sy findings available
Completed by								perfor	med? 2 🔼 No	deat	h?	2 🗆 No
20 01	25. Was case referred to medical examiner?	Hospital:			26. P	lace of Death	(Check or	ly one)				
ŀ	1 Yes 2 No 27. Manner of Death	1 Inpatier 28a. Date of injury		Outpatient  o. Time of	3 DOA 28c. Injur	4 🗠 Nurs		5 Reside			pecify)	
	1 ⚠ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day,	Year)	injury	work			i. Describe no	ov injury	occurred		
- 1	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, (Specify)	, farm, stree	t, factory, office		28f	Location (St City or Town		d Number or	Rural	Route Number,
												se(s) and manner state
	(Check 2 L Medical Examin	ner: On the basis of exa	best of my k	nowledge, d	owledge, death occurred at the time, date and place, an 29c. License number					and due to the cause(s) and manner a 29d. Date signed (Month		
	(Check 2 L Medical Examin	ner: On the basis of exa	best of my k	nowledge, d				2	29d. Date	e signed (M		
Medical	(Check 2 Medical Examinonly one) 3 Certifying Nurs  29b. Signature and title of certifier	ner: On the basis of exa e <b>Practitioner</b> : To the	best of my k		29c. Licenso	e number	_	2		e signed <i>(Me</i>	onth, E	Day, Year)
Medical Certificate:	(Check 2 Medical Examironly one) 3 Certifying Nurs  29b. Signature and title of certifier  30. Name and godress of person who compared to the	ner: On the basis of exa e Practitioner: To the	best of my k	a) (Type, Prii	29c. License D47	e number	20				onth, E	Day, Year)
Medical	(Check 2 Medical Examinonly one) 3 Certifying Nurs  29b. Signature and title of certifier	ner: On the basis of exa e <b>Practitioner</b> : To the	best of my ki	a) (Type, Prii Road	29c. Licenson D47 nt) Rockvi1	e number	) 20	852			onth, E	Day, Year)

DHMH 17 Rev 06-2011

12-07405		Ple	ease Ty	e or	Print i	n Bla	ck Ind	elible	lnk. I	Ensure	All C	Copie	s Are L	egib	le.			
_aquasia Lashay			St	ate o	f Maryla	and /					d Men	ital Hy	/giene		2	01	2 336	Section 1
_		1- For State Registrar					Certi	ficate c	of Dea	ath			2 D 1 - (D	Reg. N	lo.			_
Physiciar Medical Examin	er	1. Decedent's Nam LaQuas	ia	La	shay		Wats	son <del>-I</del>	arm	er-			2. Date of D Month Septem	Da ber 30	0, 2012		3. Time of Death 1253 hrs	
		4a. Facility Name (i Southern M				umber)			4b. City Clin	ton	Location	of Death		4c. County of Death Prince George's				
Funeral	╗	5. Social Security N		6. Sex		7. Age	(In yrs. last		if Ur Mor	nder 1 Year		er 24Hrs. Min.	-	,		9. Birti Foreign	place (State or	
Director		212-49- Usual Residence o		1 N	1 2 X F		15	5 Yr		itris Days	Hours	S IVIII I.	12/	01/	1996		intry) MD	_
any	ŀ	10a. State	10b. County			1	Oc. City, To	own or Loca	ation							П	10d. Inside City Limits	
nd show		MD	Char	les			Wald	lorf									1 Yes 2 X No	
Maryls 28a-f	ğ	10e. Street and Nu	mber					10f. Zip Code						10g. (	Citizen of Wha	at Coun	try?	
th the 23a or notifie	蒷	2713 Re	d Lio					in U.S. 13. Was Decedent of Hispanic Origin? (Speci						United Sta				_
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status  1 X Never Marri	ed 2 M	arried	12. Was De Armed F	orces?							ecify Yes or Rican, etc.)				an Indian, Black,	
fter de l'', or		3 Widowed	4 Div	orced If	1 Yes Yes, Give Ye		X No	1	Yes	2 X No	specify:				Specify: Black			
iours a	<u>8</u>	15. Decedent's Ed	• • •	cify only	highest gra		,	6a. Decede		al Occupati vorking life.				16	o. Kind of Bus	iness/Ir	ndustry	
36 an 72 h	Completed	Elementary/Seco	ondary (0-12)		College (	1-4 or 5+	+)				20		,		مان مامد	~ ·	.h 1	
21215-0036 Juld be filed within 7 Mental Hygiene. The cerent, the Medic	Ë.	17. Father's Name	(First, Middle	Last)				51	ude		18.Mother	r's Name	(First, Middle		ublic en Surname)	50	:11001	-
215 oe file ntal Hy ked o	Re											ele	er					
221 hould hould is man	₽	19a. informant's Na								,					City or Town			
MD and 2 sho salth and em 27 is raumati	ŀ	James P 20a. Method of Dis		mer	/Fat	her	20b. Pla	2 2 6 6 ace of Dispo				th I	Date	Wal 120	ldorf, MD 20601  Oc. Location - City or Town, State			_
Ore ges 1 2 t of Hi		1 X Burial 2		3 🗌	Removal f	rom Stat	e cre	matory or c	ther plac	ce)	•							
Baltimore, bernit. Pages 1 an Department of Hea Important: If iter	ŀ	4 Donation 5 21. Signature of Fu			94		Saci	red H	Hear Name ar	t Ce	me.	T:0/	09/12	Fur	La Pla	ata	, MD c., P.A.	_
Balt permit. Depart Import		alini	nll	10	the	00	MO 15										, MD 2064	1.
Physician	7	23a. Part I. Enter the				caused th	he death. D	o not enter	the mod	e of dying,	such as c	ardiac or	respiratory	arrest,	shock, or hea	rt	Approximate Interval Between Onset and	ı
/Medical Examiner		Immediate Cause ( or condition resulting			pertr			diomy	70pa1	thy							Death	_
	-	Sequentially list co		b.	ie to (or as	a consec	querice or).								-			
	Je.	if any, leading to in cause. Enter Under	nmediate		ue to (or as	a consec	quence of):							_				
	Examiner	(Disease or injury to events resulting in	hat initiated	c.	ue to (or as	a consec	quence of):											-
and ecul	ᇛᅡ			.27,per me,g933 11-5-12 sm									,	_				
O, be ex	[	X UNPENDED		X					me,	g933	11-5-	-12 s	sm 		00d Data of	1-11		_
876 tificat ting phy		IF FEMALE: 23b. Was decedent past 12 months	pregnant in the	ne	23c. If yes,	birth		2 🔲 F	etal deat	th 3 [	Ectopie	c pregnar	ncy		23d. Date of o Month		ay Year	
OX 6	Physician/Medic	1 Yes 2 🗸 I		known	4 Preg		me of deat	5 (	Other (Sp	pecify)								
trihe de by the		Part II. Other signi	ficant condi	ions c	ontributing t		but not resi	ulting in the	underlyi	ng cluse g	iven in Pa	art I.	23e. Die	d tobac	co use contrib	oute to t	he cause of death?	-
res tha	g G												1 🔲 `	Yes 2	No 3	Prob	ably 4 🗸 Unknown	
rds v requi	Completed												24a. Wa	as an topsy	pı	ior to co	opsy findings available empletion of cause of	,
Reco	ē												1 <b>✓</b> Ye	rformed s 2		eath? ✔ Ye:	2 No	
certific	Be	25. Was case refer examiner?	red to medica		spital:						of Death	<del>`</del>				1		_
f Vid	의		2 No		' '			R/Outpatier 8b. Time of		DOA 28c. Injur			g Home 5		idence 6 injury occurre	Other:		_
nding r. Aft	<u></u>	1 Natural	5 Pen		28a, Date (Mont	h, Day Yea	ar)	OD: 111110 01	n jury		'es 2				,,			
ViSic or Atte ter dea birecto	lica	2 Accident 3 Suicide		stigation Id not be	28e Pla	ce of Inju	ıry - At hom	e, farm, str	eet, facto	ory, office b	uilding, et	tc.	28f. Location or Town			r or Rur	al Route Number, City	_
Divinital of the cours at the course at	Certification	4 Homicide	dete	rmined	(Specify										_			_
	Medical	29a. Certifier 1 (Check only one) 2	CertifyIng P Medical Exa	miner:	n: To the be on the basis and manner	of exam	knowledge ination and	, death occi l/or investig	urred at t ation, in	the time, da my opinion	ite and pla , death oc	ace, and ccurred at	due to the ca t the time, da	ause(s) ate and	and manner place, and du	as state ie to the	d. cause(s)	
F 3 5 8	Me	29b. Signature and	title of certific		and Harille	stated.			2	9c. Licens					d. Date signe		th, Day, Year)	_
		h	in							O.C.I	M.E.			0	ctober 1,	2012		
	İ	30. Name and addr			mpleted cau dical Exa				ore Str	eet. Balt	imore.	MD 21:	223					
		9, 1410								A	- '							_

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 LM 2012 4:05 РМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9505 Dogwood Park Street Capitol Heights Prince George's Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Date of Birth 9. Birthplace (State or Foreign Months 1 □ M 2 □ F Hours (Month, Day, Year) 10/25/1920 216-12-4059 Maryland **Director** 91 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits Director MD Prince George's 1X Yes 2 □ No Capitof Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9505 Dogwood Park Street 20743 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian the Medical Examiner Black, White, etc ō ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural", Completed 3 X Widowed 4 Divorced Year or Dates Black Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) 12 Secretary Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Arthur Jackson Lillian Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne C. Thomas / Daughter 9505 Dogwood Park Street, Capitol Heights, MD 20743 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 10/19/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine DI Cause (Disease or injury that initiated events and Due to (or as a consequence of resulting in death) Last -burialattending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 12 months? 2 No in the past 12 Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.0. Part II. Other signi icant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 🗌 Yes 2 N 3 Probably 4 Unknown peen ERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy this certificate 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Desidence} \) 6 \( \text{Other} \) Other (Specify) 2 3 ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funer of the function of the functio Matural 5 Pending 2 No Accident Investigation 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. title of certif 29b. Signature ar 29d. Date signed (Month, Day, Year g 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 LIN THICHM IN 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2 Per PHY C933 11/16/2012 JH OF Health and Mental Hygiene 33618 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 09 Physician/ October 8, 2012 9:30 AMM Arletha P. Bogee Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford 3405 Lansdowne Court Edgewood If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8 Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Director 420-22-2587 1 □ M 2 🗓 F Alabama 89 Dec 6, 1922 Usual Residence of Decedent or 28a-f show notified at 10d Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The strength and Mental Hygiene item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 Yes 2 No Edgewood Harford MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21040 USA 3405 Lansdowne Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2X No Specify Year or Dates un un 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lelar Jones John Powell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara Reed-Pearson/daughter 3405 Lansdowne Court Edgewood, MD 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Page 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) n Nice License 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Ronald S Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Dily to for as a consequence of cause. Enter Underlying that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ò Month Pregnant
Unknown Pregnant at time of death Other (specify) be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires 3 Probably Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 Yes 2 No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, To Be Other: 1 Yes 4 Nursing Home S Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 7. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 
Yes 28d. Describe how injury occurred Certificate 5 Pending Natural 2 No Accident Suicide Investigation Director Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined the Hospital 24 hours a Funeral ( Medical 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

completely

within 2 To the I

29a. Certifier

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

completed cause of death (Item

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

da Gace

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 14. 2012 11:00 PM Jack William Brown Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Aberdeen Harford 24 Lewis Drive 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) Hours Min. 215-56-3008 Director 1 ⊠ M 2 □ F Yrs 62 Sept. 18, 195b Maryland Page 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Health end Mental Hyglene. ent: If Item 27 is merked other then "nature!", or Items 23a or 28a-f sho 10a. State 10b. County ed other then "naturel", or items 23a or 28a-f sho event, the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24 Lewis Drive 21001 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: 3 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) th end Mental Hyglene.
7 is merked other then treumetic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) UNKNOWN UNKNOWN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Jack William Brown Sr. India Anna Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Brown / Wife 24 Lewis Drive, Aberdeen, MD 21001 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Depertment of importent: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Thomas Run Ch. Cem. 10-17-12 Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Hom 1317 Cokesbury Rd., Home, P.A. Rd., Abingdon, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final etwhatic Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir the ettending physician end ched for use es the burial-transit The lew requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month vurs effer death.

vurs effer death.

erei Director. After this certificete has been signed by the effilled in by the funerel director, pege 2 should be deteched f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? وَ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☑ No 1 Yes 2 🗌 No Hospitel or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital: 1 Yes 2 • No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident М Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospitel within 24 hours e To the Funerel C completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) filed (Month, Day, Year) QCT 1 9 2012 32. Registrar's Signature Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle | ast) 2. Date of Death Physician/ Month 2012 Balling Oct. Barbara N. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cambridge Dorchester Co. Mallard Bay Nursing Home 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months (Month, Day, Year) Hours Director 212-09-7439 1 🗆 M 2 🔀 F Oct. 29,1916 Maryland 95 Usual Residence of Decedent 28a-f show ms 23a or 28a-f shomust be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MDDorchester Cambridge 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21613 United States 5559 Morris Neck Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Force Black, White, etc. or i Completed by 1 Never Married 2 Married 1 Yes 2x If Yes, Give Year or Dates. 2x No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify. "natural", 3 ₩ Widowed 4 □ Divorced White Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the should be filed with and Mental Hygien 7 is marked other the 10 Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John O'May Martha Liedke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Richard E. Balling (Son) 5559 Morris Neck Road Cambridge, Maryland 21613 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place) 10/18/2012 Oak Lawn Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Lice Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the IF FFMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 menths? Month Day Year signed by the a 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 1100 certificate 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending work? 1 Natural 5 Pending 2 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Sertifying Nurse Practitioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

29b, Signature and title of

19

Registrar DHMH 17 Rev 06-2011 Bramble Street Cambridge

impleted cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

12-07803 Ashley Marie Bolgiano

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 33621

		1- For State Registrar		Certific	cate of D	eath			Reg. No	D	1 2 0 0 0 1		
Physicia	an/	Decedent's Name (First, Middle,Last)	ANO					2. Date of Month	Death Day er 14, 20	Year	3. Time of Death 1700 hrs		
Medical Exami	ner	ASHLEY MARIE BOLGI  4a. Facility Name (if not institution, give str			4b. (	City, Town, o	r Location o			012 c. County of Dea			
		615 W. Baker Avenue	,			bingdon				Harford			
Funeral Director		5. Social Security Number 6. Sex 19-31-2686		n yrs. last bi 1		f Under 1 Ye Months Da		1.54%	of Birth(MN 31/19	Fore	irthplace (State or sign country) MD		
any .		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Tow	n or Location						10d, Inside City Limits		
<b>≥</b>		MD HARFORD		ABING	DON						1 Yes 2 No		
te Maryland or 28a-f show	Director	10e. Street and Number			10	of. Zip Code				itizen of What Co	untry?		
h the N.		615 W. BAKER AVE				21009			US				
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Isnt: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married	. Was Decedent Eve Armed Forces? Yes 2 X		If Yes,	specify Cuba	n, Mexican,	in? ( Specify Yes o Puerto Rican, etc.		White, etc.	erican Indian, Black,		
irs afte	۵	3 Widowed 4 Divorced of 15. Decedent's Education (Specify only him.	Dates:	ted) 16a		s 2 N		kind of work done	16b.	Specify: WH Kind of Business	ITE //Industry		
0036 within 72 hours after giene. ber than "natural", o	Completed		College (1-4 or 5+)		during most	of working life	e. DO NOT	use retired)					
9036 within ene.	dm		2+		STUDENT					OLLEGE			
21215-0036 nuld be filed within 7 Mental Hygiene. marked other than a cevent, the Medica	Be Co	17. Father's Name (First, Middle, Last)  KEITH VINROE						s Name (First, Mid THA CECEI					
D 212 should be and Ments 7 is mark	TO B	19a. Informant's Name/Relationship (Type,	Print )	19	9b, Mailing Ad	dress (Stre		ber or Rural Route			te, Zip Code)		
MD id 2 shoulth and in 27 is sumati		ELLEN PEARCE-AUNT									MD 21009		
or tra		20a, Method of Disposition  1 Burial 2 X Cremation 3 F	Removal from State		of Disposition story or other p		emetery,	Date	20c	. Location - City o	or Town, State		
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other Specify:		ATLAN	TIC CR			10/18/12		LEN BURN			
Baltimore, MD permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is injury or other traumat		21. Signature of Fur eral Service Licensee						SCHIMUNE RD BEL			ME OF BELAIR		
Physician		23a. Part I. Enter the disease, or complicati	ons that caused the	death. Do r							Approximate Interval Between Onset and		
Medital Examiner	9	failure. List only one cause on each line.  Immediate Cause (Final disease a. Diabetic Ketoacidosis											
LAMITHE			ence of):										
	<u></u>		to (or as a conseque	ence of):									
	Examiner	cause. Enter Underlying Cause (Disease or injury triat initiated events resulting in death) Last	to (or as a conseque	ence of):	< 20				_		-		
cuted nd transit	Ä	d.									<u>,,</u>		
760, icate be executed physician and the burial - transit	Medical	X UNPENDED AM	MENDED 23a, 2	7,per	me, g93	32 10–	24–12	Sm					
68760, certificate be nding physicise as the buri		23b. Was decedent pregnant in the	3c. If yes, outcome of		2 Fetal d	eath 3	Ectopic	pregnancy	23	3d. Date of deliver Month	ry Day Year		
Box 687  The death certification in the attending property of the death of the deat	Physician/	past 12 months?  1 Yes 2 No 9 V Unknown 1	Pregnant at time	and the attention	- =	(Specify)			.				
BOX the death y the atte	Phys	Part II. Other significant conditions con		t not resultir	ng in the unde	rlying cause	given in Par	† 1 23e. [	oid tobacco	use contribute to	the cause of death?		
Division of Vital Records, P.O. Box 687 tall or Attending Physician: The law requires that the death certifit is after death.  *I Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as the content of the state o	ģ	Tattin Gulor digililloani Golfandi Golfa	induiting to down bu	i i i i i i i i i i i i i i i i i i i	.g ao aao	nymig oddoo	9,10,1,111				obably 4 🗹 Unknown		
rds, require	Completed								Vas an utopsy		utopsy findings available completion of cause of		
Vital Records ysician: The law requi	<u>p</u>							<del></del>	erformed? es 2 1	death?			
al R	0	25. Was case referred to medical				26.Plac		Check only one)					
Vita hysici	TO B	examiner? 1 ✓ Yes 2 No	TInpatient		Outpatient 3			Nursing Home 5		ence 6 🗸 Othe	er: Scene		
n of ding P h. After		27. Manner of Death  1 X Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b.	Time of Injury		uryatWork? Yes 2 □		ibe how in	jury occurred			
Sion Atten	icati	2 Accident Investigation	28e. Place of Injury	- At home, f	arm, street, fa				on (Street	and Number or R	ural Route Number, City		
Divisior ospital or Attend hours after death ineral Director:	Certification:	3 Suicide 6 Could not be determined	(Specify)				-		vn, State)				
Division of Vital Records, P.O. I To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.		29a. Certifier 1 CertifyIng Physician: (Check only one) 2 Medical Examiner: On	To the best of my kn	owledge, de	ath occurred a	at the time, d	late and place	ce, and due to the	cause(s) a	nd manner as sta ace, and due to tl	ted. he cause(s)		
To tl withi To tl	Medical	29b. Signature and title of certifier	manner stated.		3	29c. Licen				Date signed (Mo			
, d		higher -				0.C.	M.E.		1	tober 15, 201			
DK PLIN	}	30. Name and address of person who comp				<u> </u>							
/ · /		Ling Li, MD Assistant Medic			Baltimore S	Street, Bal	timore, M	1D 21223					
St Regist	ate	31. Date filed (Month, Day, Year)  OCT 1 9 2012	32 Registrar's S	Signature	back	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/  $A^{\mathsf{M}}$ 10 2012 Anthony Joseph Brodziak 4.45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caton Manor Baltimore If Under 24 Hrs. 5. Social Security Number 6. Sex If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Davs (Month, Day, Year) 01/10/1915 Country) Pennsylvania 1 ₹ M 2 □ F Director 382-07-5783 97 Yrs Usual Residence of Dece permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If Item 27 is merked other than "neturel", or Iteme 23e or 28e-f show eny injury or other treumatic event, the Medical Evans for must be mustled at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1X Yes 2 No Lynnbrook MD Anne Arundel 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21225 621 Douglas Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ☑ Widowed 4 ☐ Divorced Specify Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Pipefitter** Federal Government 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٥ Anthony Brodziak, Sr. Mary Krent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas A. Brodziak / Father 621 Douglas Street, Lynnbrook, MD 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 10/18/2012 Beltsville, MD . Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 01413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) elar Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at id be detached fo a 🗆 Linknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No certificate 1 Yes of Vital in 24 hours after death.

the Funeral Director: After this certific npietely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 8 Other: 1 Tes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ☐ Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the f 29b. Signature and title of certifier 29c. License number 30. Name and adverses of person who completed cause of death (Item 23a) (Type, Print) 2122 Ferry Rd Ballima

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month LEONARD BERGER 2:51 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital Bultimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Country) Director 252-38-2176 1 X M 2 D F 84 11/24/1927 FL. 10a, State 10b. County r than "natural", or Itams 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits BALTIMORE 1 🗆 Yes 2 🙀 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4001 OLD COURT ROAD, #104 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ۾ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced If Yes Give Completed Specify: Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hyglane. Elementary/Secondary (0-12) College (1-4 or 5+) 5+PHYSICIAN MEDICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) TSAAC BERGER IDA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SARA ANN BERGER/WIFE 4001 OLD COURT ROAD, #104, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pege 1 e
Dapertment of H
Important: If its
any injury or ot Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH EL MEMORIAL PK 10/18/2012 RANDALLSTOWN, MD 21. Sign fure Funeral Seprice Licen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Physician/ Onset and Death Stesis disease or condition 24 hours Medical resulting in death) Due to (or as a nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requiras thet the daeth cartificata be axecuted within 24 hours elfard dath.

Of the Funeral Director, After this cartificata hes been signed by the ettending physician and complately filled in by the funeral director, pega 2 should be detached for usa as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ξ failure hyporlipidensia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed vascular 24b. Were autopsy findings available prior to completion of cause of death? Coronora disease 24a, Was an auton pulmmary hypertension 1 ☐ Yes 2 ☐ No 25. Was case referred to ical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Matural 5 Pending iniury 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD PAS # 18263 October 16,2012 person who completed cause of death (Item 23a) (Type, Print) Shakir Omar Sinai MD Bul timore

ODI

OCT 1 9 2012

31. Date filed (Month, Day, Year)

State

Registrar

DHMH 17 Rev 06-2011

Registrar's Signature

DX 68760 Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Octobe 2012 03:30 AM BATTISTA PATRICE BREITEL Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner of Baltimore Baltimore Hospital N/A Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex Funeral (Month, Day, Year) Days Hours Director 070-14-6324 1 🗆 M 2 🛣 11/20/1920 NY Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show envingury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Director 1 √ Yes 2 □ No BALTIMORE N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 7211 PARK HEIGHTS AVENUE, #204 21208 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) BROKER REAL ESTATE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည SARAH HYMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8712 PINE MEADOWS DRIVE, ODENTON, MD ANDREW PAEZ/GRANDSON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 10/18/2012 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) HAR SINAI CEMETERY 21. Signature o Funeral Service Sicensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical 6 days Examiner hatal Sequentially list conditions, Due to (or as a consequence of) Examine if a y, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate or execution within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident
☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) talens October 17 2012 18261

Registrar
DHMH 17 Rev 06-2011

State

of Baltimore, 2401 W. Belvedere Ave, Balto, MO21215

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fallano

OCT 1 9 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Joseph Chite 14, 2012 0630 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Sanctuary @ Holy Cross Burtonsville If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Apr 11, 1915 **Funeral** 9. Birthplace (State or Foreign Min Director Washington DC 1 X M 2 🗆 F 577-09-7171 97 Usual Residence of Deced works Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Tes 2 No Howard Glenwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 14597 Mustang Path 21738 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Arroed Forces?

1 Yes 2 No Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2X No Specify. Specify: White 3 XWidowed 4 Divorced Year or Dates. WWII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Food Clerk Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Antonio Chite Antoinette Lombardo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 14597 Mustang Path Glenwood, MD 21738 Frances Virginia Noyes/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 10/18/12 Department of Important: If any injury or Woodbine, MD 4 Donation 5 Other (Specify) f Funeral Service License . Signat Golfing and the Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Years Immediate Cause (Final Ph\_si\_i\_n/ disease or condition resulting in death) Chronic Kidney Disease Medical Due to (or as a consequence of) Examiner Bladder Outlet Obstruction months Sequentially list conditions, cause (Disease or injury Due to (or as a consequence of). Exami Pneumonia days as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Electrolyte Imbalance days IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day 5 Other (specify) Pregnant at time of death Month Yes 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Tes 2 No 3 Probably 4 X Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred **X**Natural 5 Pending injury work? death. ☐ Accident ☐ Suicide Investigation 6 Could not be

Box 68760 P.O. Division of Vital Records, or Attending Physician: the Hospital

within 24 hours after deat To the Funeral Director:

filled in by

Medical

4 Homicide

29b. Signature and title of certifier

aura)

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ND 1500 forest glen and silver spring 20910

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Registrar

1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Christopher L. Conner  $AM^M$ <u>October</u> Medical :34 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Sept 22 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 X M 2 A F Days 217-70-7900 **Director** 55 Tennessee Usual Residence of Decedent 28a-f shov 10a, State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Edgewater ō 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 1730 Potomac Road 21037 USA · death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ģ 1 Yes 2 No Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify. white 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. d other than " Elementary/Seconday (0-12) College (1-4 or 5+) 10 self employed carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I Department of Health and Should be Department of Health and Menta Important. If item 27 is marked any injury or other traumations. ပ Joseph Black Conner Jr Edna Earnistene Leach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Funeral Se 22. Name and Address of Facility
State Anatomy Board
Baltimore, MD 2120 hopady S 655 W. Baltimroe Street timore. . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition FRM Medical resulting in death) Due to (or as a cool equence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performe page 2 • Hospital or Attending Physician: The 124 hours after death.
• Funeral Director: After this certificate h 2 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital 2 200 1 🗌 Yes မ 1 Dopatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation completed filled in by the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the P only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Pay, Year) 10 7 7 -12 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 19 Registrar

12-07759 Brenda Lvnn Cox Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

renda Lynn Cox		For State Critical Certific	cate of D		a monta		g. No. 2	012 3362
Physicia		egistrar . Decedent's Name (First, Middle,Last)				2. Date of Death	1	3. Time of Death
ledical Examin	er	Brenda Lynn Cox				Month October 13		0540 nrs
		la. Facility Name (if not institution, give street and number)			Location of D	eath	4c. County of Harford	of Death
1		Upper Chesapeake Medical Center		Bel Air	ar If Under 2	Nes & Date of Rid		Birthplace (State or
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bit	· · ·	f Under 1 Yea Months Day		Min.		Foreign
Director	L	213-66-8764 1 M 2 X F 48	Yrs.			Mar. 4	, 1964	Country) Maryland
át	-	Java   Residence of Decedent	n or Location					10d. Inside City Limits
ow any								1 X Yes 2 No
Maryland 28a-f show d at once.	혉	Maryland Harford Bel Ai		Of, Zip Code		10	g. Citizen of Wh	nat Country?
e Mar or 28;	Director	708 Reedy Circle		21014			USA	
		11. Marital Status 12. Was Decedent Ever in U.S.	13. Was D	ecedent of His	spanic Origin?	( Specify Yes or No-		- American Indian, Black,
ath w	Funeral	1 Never Married 2 Married Armed Forces?  1 Yes 2 No	If Yes,	specify Cubar	n, Mexican, Pu	ierto Rican, etc.)	White	e, etc.
fter de		3 Widowed 4 Divorced If Yes, Give Year	1 Ye	es 2 X No	specify:		Specify:	White
5-0036 led within 72 hours after Hygiene. other than "natural", other than "natural",	P P	15. Decedent's Education (Specify only highest grade completed) 16a.	. Decedent's l	Usual Occupa	ation (Give kind e. DO NOT use	d of work done	16b. Kind of Bu	siness/Industry
72 hc	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most	of working inc	J. DO 1101 40.	710.1104)		
036 vithin 72 ene. er than Medical	티		Waitre	ess	40.14-4-4-1	Jame (First, Middle, M		taurant
15-00 illed with Hygien d other		17. Father's Name (First, Middle, Last)				ey Faye G		)
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	o Be	Bradley Meola Riley  19a. Informant's Name/Relationship (Type, Print)  15	9b. Mailing Ac	ddress (Stre		r or Rural Route Num		n, State, Zip Code)
O # 5	ř	David M. Cox / Spouse	-	,		Bel Air, I		
ore, MD es I and 2 sh of Health an If item 27 i	ŀ	20a. Method of Disposition 20b. Place	e of Disposition	n (Name of ce		Date		City or Town, State
OF ges 1 it of 1 it. If i		1 Burial 2 Cremation 3 Removal from State	atory or other		IIC 1	0-18-2012	Bel Air	r, Maryland
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum	ŀ	4 Donation 5 Other Specify: ROSE  21. Synattys of Fund all Service Licental				Home, P.A		
Dem Dem inju	-	Month of man	11211	7 Cakas	abura E	Cad Ahin	adon Mi	21009
Physician	7	23a. Part I. Enter the disease, or complications have a seed the death. Do r failure. List only one cause on each ins	not enter the	mode of dying	, such as card	iac or respiratory arre	est, shock, or he	art Approximate Interval Between Onset and
IMedical Examiner	Ī	Immediate Cause (Final disease a Morphine Intoxic	ation					Death
Examine		or condition resulting in death)  Due to (or as a consequence of):						
	اير	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
	Ě	cause. Enter Underlying Cause						
sit.	xar	events resulting in death) Last Due to (or as a consequence of):						
60, ste be executed hysician and e bunial - transit	Physician/Medical Examiner	MENDED 23a,27,28a	a-f.per	me.29	932 10-	25-12 sm		
60, nte be ex hysiciar e burial	ğ						23d. Date of	delivery
876 ificate ig phy	<u>Ş</u>	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnanc 1 Live birth		death 3	Ectopic p	regnancy	Month	Day Year
Sox 6876 death certificate e attending phy for use as the	icia	past 12 months?  4 Pregnant at time of death	5 Other	(Specify)			ļ	
Box 6871 e death certifica the attending pled for use as th	hys	1 Yes 2 No 9 V Unknown 9 Unknown	10 1- 1b	lastria a sarras	siven in Best	23e Did to	hacco use contr	ibute to the cause of death?
ords, P.O. B w requires that the d is been signed by the		Part II. Other significant conditions contributing to death but not result	ang in the and	lenying cause	giveninrait	1 Yes		
S, F uires an sign	8						an   24b. '	Were autopsy findings available
aw req	픮					autop	sy	prior to completion of cause of death?
Rec The la	Completed by					1 ✓ Yes	2 No 1	✓ Yes 2 No
Division of Vital Records, P.O. real or Attending Physician: The law requires that the rs after cleath.  *I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Be	25. Was case referred to medical examiner? Hospital: 4 I legation 1 2 EB/			Other		Residence 6	Other:
F Vid	٩	1 ✓ Yes 2 No	/Outpatient 3		jury at Work?		now injury occur	
n of ding Pt . After funeral	Ë	1 Natural (Month, Day, Year)		_   ₁□	Yes 2 K N	subject	took p	rescription
ivisior or Attend after death Director:	cati	2 Accident Investigation 10-12-12 1	d U9:00	factory, office	building, etc.	modiant	ion	
Divi	Certification:	Suicide Could not be determined (Specify) Tormhouse			_	Bel Air	tate) / US R C, MD.	er or Rural Route Number, City eedy Circle
fospit 4 hour 7 uners	Ö	29a. Certifier 1 Certifying Physician: To the best of my knowledge, of	death occurred	d at the time, o	date and place	e, and due to the caus	e(s) and manne	r as stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/o and manner stated.	or investigation	n, in my opinio	on, death occu	rred at the time, date	and place, and	due to the cause(s)
To with	Me	29b. Signature and title of certifier		29c. Licer	nse number			ned (Month, Day, Year)
OKI		Carol HADDOAN		0.0	C.M.E.		October 13	3, 2012
		30. Name and address of person who completed cause of death (Item 23a	a)			ND 01000		
10 h		Carol H. Allan, MD Assistant Medical Examiner	900 W. Ba	aitimore Sti	reet, Baltım	iore, MD 21223		
	ate	31. Date filed (1901), Day Year 12 32. Registrar's Signature	bares	,				
Regist	ıŒ	OGME						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Physician/ Ernesto Liwanag Centeno, M.D. 9:53 AM Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** Franklin Square Baltimore osedale Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Age (In yrs. last birthday) Min (Month, Day, Ye 217-19-7691 1940 **Director** 1 🔀 M 2 🗆 F 72 Jan. **Philippines** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10c. City. Town or Location Director MD Baltimore 1 Yes 2K No Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 USA 8843 Trimble Way tems 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, 27 is marked other than "natural", or iter traumatic event, the Medical Examiner Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 Specify: Asian 1 ☐ Yes 2 No Specify. Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Family Doctor Own Practice Be 18. Mother's Name (First, Middle, Maiden Surname)
Leonor Liwanag 17. Father's Name (First, Middle, Last) Ricardo Centeno 19a. Informant's Name/Relationship (Type, Print) Ricardo F. Centeno- Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 8843 Trimble Way Rosedale, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of 1 X Burial 2 Cremation 3 Removal from State Gardens of Faith Cem 10/15/12 Rosedale, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home Inc. 9705 Belair Rd Baltimore, MD 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph. sician/ IZUre disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events burial-trai resulting in death) Last Due to (or as a consequence of) Physician/Medical recent Pulseless electrical activity that the death certificate be 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Por in the past 12 months? Month Day Year 1 Yes 2 L 9 Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 24 hours after death. 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Records, Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performeda After this certificate Yes Division of Vital Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: 욘 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d, Describe how injury occurred Certificate: 1 🗹 Natural 5 Pending 1 Yes 2 No Accident Investigation e Funeral Director: pletely filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) To the 29b. Signature and title of certifie Wearpn9 who completed cause of death (Item 23a) (Type, Print) Square 9000 Franklin Swearenger Drive Registrar

3

Carol Youngell Cho	e State of Maryland / Department of										
	1- For State Certificate of Registrar	-	Reg. No.	2012 3362							
Physician/ Medical Examine	Decedent's Name (First, Middle,Last)		2. Date of Death  Month Day Y  October 12, 2012	3. Time of Death 1419 hrs							
	4a. Fadility Name (if not institution, give street and number) 8870 Columbia 100 Parkway	4b. City, Town, or Location of Death Columbia	4c. Count Howar	ty of Death							
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.	. 8. Date of Birth (MM/DD/YY	yy) 9. Birthplace (State or ForeigrHavre de Grace							
Director	214-21-2963 <sub>1 M 2</sub> F 30 <sub>Yrs</sub>	Months Days Hours Min.	May 27,1982	Countryland							
yne	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locat	ion		10d. Inside City Limits							
<b>E</b>	Maryland Howard County Columbia			1 Yes 2 No							
the Maryland a or 28s-f show tified at once. Director	10e. Street and Number	10f. Zip Code	10g. Citizen of	What Country?							
death with the Maryland or items 23a or 28a-f sho must be notified at once.	7517 Weather Worn Way Unit B.	21046		ted States							
r death with or items 23 must be no	1 Never Married 2 Married Armed Forces? If Y	as Decedent of Hispanic Origin? (Sp es, specify Cuban, Mexican, Puerto		ace - American Indian, Black, hite, etc.							
s after de real?, or niner m	A Discount of Management of the Management of th	Yes 2 No specify:	Specify	y: Korean							
hours frami	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	nt's Usual Dccupation (Give kind of woost of working life. DO NOT use retir		Business/Industry							
5-0036 ed within 72 hour tygiene, other than "natu the Medical Exan Completed	12 College (1-4 or 5+)	Unemployed	Un	employed							
5-0036 led within 7 Hygiene. t other than the Medica	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surnar								
2121 uld be fi Mental marked c event,	Samuel Minyeol Choe  Julie Cholsoon Choi  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z										
MD 21 d 2 should d 11th and Me n 27 is man		Weather Worn Way		lumbia, MD. 21046							
e, N l and J Health Fiten	20a Method of Disposition 20b Place of Dispos	sition (Name of cemetery		n-City or Town, State arford County)							
Pages nent of nent of nent of nent of nent of nent of nent. If nent of nents is nent in nent of nent is in nent in nent nent nent nent nent nen	1 Burial 2 Cremation 3 Removal from State TVans Function 4 Donation 5 Other Specify:	ervices.Inc. UCC.	16,2012 Fore	st Hill, Maryland							
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland poperment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	21. Signature of Funeral Service License Seffrey L. Gair, Sr. 132.	Name and Address of Facility Peaceful Alternatives	Funeral and Cre	ration Services, P.A.							
Physician	13a Part I/Enter the disease, or complications that caused the death. Do not enter t		monium, Maryland r respiratory arrest, shock, or I	21093–2215 heart Approximate Interval							
Medical Examiner	failure List only one vause on each line.  Immediate Cause (Final disease a Quetiapine Intoxicat:	ion		Between Onset and Death							
	or condition resulting in death)  Due to (or as a consequence of):										
ed nsit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated										
executed an and al-transit											
	■ MENDED 23a, 27, 28a-f, po	er me,g933 11-1-1	12 sm								
876C ifficate ig phys is the b	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fe	etal death 3 Ectopic pregna		of delivery Day Year							
Box 68760, e death certificate be the attending physici ed for use as the burn hysician/Med	past 12 months?  4 Pregnant at time of death 5 Of	ther (Specify)									
D. BC t the der by the a ached f	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use co	ntribute to the cause of death?							
ords, P.O.  v requires that the speed signed by should be detach			1  Yes 2 ✓ No	3 Probably 4 Unknown							
ords, w requir ls been s should bletec			24a. Was an 24b autopsy	o. Were autopsy findings available prior to completion of cause of							
Records, The law requires ficate has been significate base 2 should be Completed			performed? 1 ✓ Yes 2 No	death? 1 ✓ Yes 2 No							
n of Vital Recting Physician: The I. After this certificate funeral director, page on: To Be Con	25, Was case referred to medical examiner?	26.Place of Death (Check of Other Nursing									
of Vi( ing Physic After this funeral dir.	1 V Yes 2 No Impatient 2 Erroutpatient		g Home 5 Residence 6	Other: Scene							
OD C cending sath. or: Af the fun	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation fd 10-12-12 fd 14:	1 1 Dm 1 Yes 2 X No	intentional i	ngestion of medication							
Division o spital or Attending nours after death. neral Director: After filled in by the fune Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre	et, factory, office building, etc.	28f. Location (Street and Nur or Town, State) 8870	mber or Rural Route Number, City Columbia 100							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Peneral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burifledical Certification: To Be Completed by Physician/Med	4 Homicide determined (Specify) Hotel Room  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occu	1	Pkwy Columb								
To the Ho within 24 h To the Fu completely	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigal and manner stated.	tion, in my opinion, death occurred a	it the time, date and place, and	d due to the cause(s)							
A F S F S	29b. Signature and title of certifier	29c. License number		gned (Month, Day, Year)							
(2)	30 Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	October	13, 2012							
370	30 Name and add/ess of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 90	0 W. Baltimore Street, Baltin	more, MD 21223								
State Registra		ald.									
DHMH 17 Rev 1/2001	ORIGINA		GEASE								
OCME 2000	3,40,0		( A 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1								

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Dorinda Jean Cartwright 17:11 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Maryland Rockville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours (Month, Day, Year) Country) Director 195-34-2617 70 1 🗆 M 2 🖾 F Yrs 9-25-1942 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d Inside City Limits with the Maryland Director Montgomery Rockville 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5809 Vandegrift Avenue 20851 United States death v 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked other any injury or other 2 ş 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White Completed 3 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) National Archives - Technician Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Cartwright Helen Cunningham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5809 Vandegrift Avenue, Rockville, Maryland 20851 Susan Saylor - Companion 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 10-22-2012 Falls Church, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Danzansky-Goldberg 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final metastatic Onset and Death Pnysician/ liver cancer Medical resulting in death) Due to (or as a consequence of): Examiner liver failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine acute vena attending physician and for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Physician/Medical Division of Vital Records, P.O. Box 68760⊄ IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Day Pregnant at time of death ed by the a 1 Yes 2 L 9 Unknown Yes 2 No g 🔲 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🗹 No Hospital: Other: မြ 1 PInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No XNatural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive, Pockville, Huashera W, MD 9001 Medical Center 31. Date filed (Month, Day, Year) State 1 9 2012 Registrar

Cartwright

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First Middle | ast) 2. Date of Death Physician/ Month James Edward Cordrey M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7934 Bank Street Baltimore Baltimore County 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral Director** 1**X** M 2 □ F 216-40-2701 69 June 2,1943 Maryland 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director 1 ☐ Yes 2X No MD Baltimore Baltimore Co 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7934 Bank Street 21224 United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, an "natural", or ite Medical Examiner Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2X No Specify Specify 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 all Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years WJZ TV <u>Camera Man</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is mark-any injury or ---other traumatic Edward Cordrev Pauline Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore Maryland Mrs. Anna M. Cordrey (Wife) 7934 Bank Street Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State ematory or other place, Oald Lawn Cemetery 10/22/2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Sign 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc U 7922 Wise Ave. Dundalk, Maryland Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph, sician/ disease or condition Medical resulting in death) VASCULAR **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami and resulting in death) Last physiciar Physician/Medical the ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 control 1 Yes 2 No 3 ☐ Ectopic pregnancy5 ☐ Other (specify) Pregnant at time of death Month Day Year the hed signed by t d be detact Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 perform certificate Tobacco US 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 5 \sum Residence 6 \sum Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 5 Pending 1 Yes 2 No Investigation

Box 68760 P.O. Division of Vital Records. or Attending Physician: . Manner of Death 1 Deatural 2 Accident Certificate: within 24 hours after death.

To the Funeral Director: After the funeral by the funeral by the funeral states. 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only on 3 L Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur 29d. Date signed (Month, Day, Year) who completed cause of death (Ite/ Rosedale MD Registrar

HOWARD LOELLEN CHASE 2 PATIENT KNOWN

			Pleas	e Type or Print							7		_	ble.		
			For State	State of Mar	yland /					nd Me	ental Hy		0.0	10	00	(22
			Registrar  1. Decedent's Name (First, Middle, L	ast)		Cen	ificate o	ט זו	eatn		2. Date of De	Reg. N	0. 2	16	3. Time o	1000
	Physicia Medic		Howard L	. Chase							Month	D	ay IS Z	Year		9 PM
	Examin		4a. Facility Name (if not institution, gi				4b. City, Town	n, or l	Location of				c. County			
				Sex 7. Age (			If Under 1 Ye		If Under 2		. D (D)		NA	2.5:4		
3	Funeral Director			1 M 2 □ F	In yrs. last b			iys	Hours	Min.	Month, Da	ay, Year)		9. Birth Cour	nplace (State ntry)	or Foreign •
CHA	, A		Usual Residence of Decedent  10a, State  10b, County	/	14					0	2-18-	193	Y	/ 1	ry 19.	nd_
J	aryland 8-f sh	cto	Mal NA		Oc. City, To										100. Inside (	ity Limits
3	or 28	Dire	10e. Street and Number		12911	tim o	10f. Zip Coo	de				10g. C	itizen of W	/hat Cou	intry?	
معسهم	s 23e	Funeral Director	3801 W. Far.	rison Ave	_		2	12	-15			(	1,5,	A.		
	r death	y Fui	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces?		13. W	as Decedent of Yes, specify C	of His Suban	spanic Origi n, Mexican,	in? (Specif Puerto Ric	y Yes or No- can, etc.)	-		e - Ameri k, White,	can Indian, etc.	
	s efter	ed by	3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	0	1	☐ Yes 2 🔀	No	Specify:				Specify:	Ble	ack	
HOWARD L	2 hour	Completed	15. Decedent's (Specify only highest		10	6a. Decede	nt's Usual Oc	cupa	tion uring most o	of working		16b.	Kind of Bu	siness/lr	ndustry	
3 5	thin 7	Som	Elementary/Secondary (0-12)	College (1-4 or 5+)		life. DO	NOT use retin	red)		loxe		/	LOVE			_
	iled w	Be	17. Father's Name (First, Middle, Las	t)		_(4)	21)1-0	T		,	irst, Middle				<u> </u>	
	Id be f Mente erked etic ev	ဍ	Leonard C	hase					Hel	en	Broc	Ks				
1 SA	shou h end 7 is m rreum		19a. Informant's Name/Relationship			-	Address (Str					-				
0	end 2 Heelt tem 2		Mamie Chqj. 20a. Method of Disposition	e wife			W. 6-		riso	h At		$\overline{}$			レレス ル Town, State	
Usususy Salimon	Pege 1		1 M Burial 2 Cremation 3 4 Donation 5 Other (Spe		Lond	etery, crema	atory or other	place			-2012	Ι.	g I fi		, ,	
Acusta X	permit. Pege 1 and 2 should be filed within 72 hours efter death with the Maryland Deperment of Heelth and Mentel Hygiene. Deperment of Heelth and Mentel Hygiene. The mentel Hygiene is not strengther if the 21 is merked other then "neturel", or items 23e or 28e-f show eny Injury or other treumetic event, the Medical Evented in set to notified at once.	1	21. Signature of Funeral Service Lice		2-00-00		Name and Ad	dress								4
_	20529	3	Calton C	Douglan		11	201 MG		alloh	. 10	Bar	TV. /	ud.	2/2	-17	
73			23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final	mplications that caused the course on each line.	ne death. D	o not enter	the mode of	dying	, such as c	ardiac or r	espiratory a	rrest,			Approxima Interval Be Onset and	tween
PATI	Pnysician/ Medical		disease or condition resulting in death)	a. GASTROI Due to (or as a c	consequence	ANCE	R							$\rightarrow$	unkn	
0	Examiner	_	Sequentially list conditions,	SEPSIS											2-34	veeks
	sit d	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a c	onsequenc	ce of):										
	executed en end urlei-transit	Exar	that initiated events resulting in death) Last	c. Due to (or as a c	onsequenc	ce of):								$\dashv$		
ç	e be ex ysicien e burle	ical		d												
Olivicion of Wital Docume DO DO 80760	requires that the death certificate be been signed by the attending physici should be deteched for use es the bi	Completed by Physician/Medical	IF FEMALE:								···-					
2	ath ce	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1  Live Birth 2 4  Pregnant at ti	Fetal de	eath 3 🗌	Ectopic pregr		/				23d. Dat Mor		very Day	Year
à	the de by the	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown			Other (accord	" <i>-</i>								
	thet t	by Р	Part II. Other significant conditions		not resultin	ng in the un	derlying cause	e give	en in Part I.		23e. Did	tobacco	use contri	bute to t	the cause of	death?
Ç	aquires sen sig nould t	ted	PROSTATE CAN	CER						_	1 🗆	Yes 2	? □ No	3 🗌 Pro	obably 4 🖺	Unknown
Ş	lew re hes be	mple									24a. Was		р	Vere auto prior to co leath?	opsy findings ompletion of	available cause of
٥	n: The ificete or, pag	ပိ	25. Was case referred to medical					C Dia	ce of Death	(Charles	1 🗌 Yes				2 🗆 <b>N</b> o	
<u> </u>	ysicie s cert	To Be	examiner? 1 ☑ Yes 2 ☐ No	Hospital:	t 2 🗆 ER/	Outpatient/		Other		•	e 5 ☐ Resi	idence	6 □ Othe	r (Specif	iv)	
ť	ng Ph fter th Inerai	te:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Y	288	o. Time of injury	28c. li	njury vork?	at		d. Describe				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	ttendi deeth. tor: A	Certificate:	2 Accident Investigat 3 Suicide 6 Could no	the	411	f	M 1		Yes 2□1	$\rightarrow$						
	lor Ar after Direc d in by		4  Homicide determine	28e. Place of Injury building, etc. (		, tarm, stree	et, factory, offi	ice		28	f. Location ( City or To			r or Rura	al Route Num	ber,
-	To the Hospitel or Attending Physicien: The lew requires that the death certificate be within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be deteched for use es the bit.	Medical	29a. Certifier 1 Certifying Pl	hysician: To the best of my	y knowledg	e, death o	curred at the	time,	date and p	place, and	due to the c	ause(s)	and mann	er as sta	ted.	
	the H thin 24 the F	<b>¥</b>	only one) 3 L Certifying N	miner: On the basis of exar urse Practitioner: To the b	est of my k	nowledge, o	death occurred	at the	e time, date	and place	, and due to	the caus	e(s) and m	anner as	stated.	
4	5 <b>3</b> § 5		29b. Signature and title of certifier	YO MD			29c. Lic	ense	number	2		29d. D	ate signed	(Month,	Day, Year)	
_			30. Name and address of person wh	<i>'</i> ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	th (Item 23a	a) (Type, Pr	int)	/	1 70,	-		UC	VBE	K,	10, ×	012
4_			LINGXIANG	YE, MD	)	SI	29c. Lico 00 int) [NA]	Н	1720	ITA	L 07	F B	BAL	TII	MORE	
1	Stat Registra		31. Date filed (Month, Day, Year)  OCT 1 9 20		Signature	bar	Kal									
X	HMH 17 Rev 06-2	_	001 1 0 20	in justice	7,	7										
1																

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. hend #20b Per FH G933 11/08/2012 JH State of Maryland / Department of Health and Mental Hygiene 33633 Certificate of Death 1. Decedent's Name (First, Middle, Last) AM 2 Date of Death 3. Time of Death Month / O-Physician/ -20/2 9:00 AM Medical 8 4a. Facility Name (if not institution, give street and number Examiner Town, or Location of Death County of Death 4b. City imore Kanda 9. Birthplace (State or Foreign Age (In yrs. last birthday, 8. Date of Birth 24 Hrs. **Funeral** 1 🗆 M 2 🛂 Months Days Hours Min. Country) **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Kesvi 1 Yes 2 No none 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Completed by Funeral Koag 21208 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Newer Married 2 Married Baltimore, Maryland 21215-0036 Specify: Blac 1 ☐ Yes 2 ☑ No Specify: If Yes Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) VISC t pa Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ပ nance rown 19a. Informant's Name/Relationship (Type, Print) te Number, City-or Town, State, Zip Code) 19b. Mailing Address (Street and Nu. Kesville MD21202 ona los 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 10/31 2012 Cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State Mills 4 Donation 5 Other (Specify) *wincs* reene Funeral Bervices Signature of Funeral Service Licensee anda Vstown MD21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final EUMON1 Onset and Death Pnysician/ disease or condition resulting in death) Medical Due to r as a consequence of Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Litter children injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): attending physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown cate has been a 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed Yes 2 X 24 hours after death. Funeral Director: After this certificate 2 No 25. Was case referred to medical examiner?

1 Yes 2 No funeral director. 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital: မ 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending work?
1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the 29b. Signature and title of certifie 10 29d. Date signed (Month, Day, Year) 00061 21225 leted cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp BACT 3350 WILKENS AVE Q1)AINOO Sun MD 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8,20b perFH,G933,11/52012,WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Month 10:25PM BERRY THERINE 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GOOD SAMARITAN HOSPITAL MEDSTAR BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 1/14/1932 9. Birthplace (State or Foreign Months | Days | Hours | Min. | (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F 264-38-372 Yrs Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Yes 2 No BANTMORE 10e Street and Number ö 10a. Citizen of What Country? Funeral items 23a BEAUMONT 21212 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married 2 **X**No ö þ Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: BLACK "natural", 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) A PROFESSIONAL ASTIMORELITY JEHOOLS 2 Be 17. Eather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ OHN GLOVER MAMIE GENNERETTE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BEAUMONT · BALTO, ANORA Smith 812 Daughter MD. 21212 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of Date 2/2012 20c. Location - City or Town, State cemetery, crematory or other place) 5 Injury SARRISON FOREST BALTIMORE, MD Signature of Fulperal Service Licensee GREENE FUNERAL SUS 1 22. Name and Address of Facility VAUGHN any 905 M01665 YORK oad. 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Yea Pregnant at time of death ed by the a detached f g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? ۵ Division of Vital Records, Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy DIABETE performe certificate 1 Yes 2 🗌 **N**o director. 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 **X**0No Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) မ 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA this the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death To the Funeral Director: A Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one title of certifier 29b. Signature an 29c. License number ATTENDENG M.D 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8813 WALTHAM WOODS RD#204 PARKUILLE KAGHU NATH State 19 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gray Dunham October | 2012 1 9:45 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3112 Gracefield Rd. Silver Spring Montgomery Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Director 224-60-6138 1 X M 2 □ F 89 Illinois Feb. 11,1923 ir then "neturel", or Items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3112 Gracefield Rd. 20904 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 Gray Yes 2 No
If Yes, Give
Year or Dates 1943-49 2 Baltimore, Maryland 21215-0036 permit. Page 1 end 2 should be filed within 72 hours eft Department of Health and Mentel Hygiene. Importent: If item 27 is marked other then "neturell", 1 ☐ Yes 2 🎇 No Specify 3 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Archivist Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Chester Dunham Forrester The1ma Mildred Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgiana P. Dunham / Wife 3112 Gracefield Rd., Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Injury or 4 ∑ Ponation 5 ☐ Other (Specify) Uniformed Sers. Univ: 10/16/2012 Bethesda, MD 21. Signature of Funeral Service Lio 22. Name and Address of Facility
Rapp Funeral and Cremation Services Š M00382 933 Gist Ave., Silver Spring, 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death
10 MONTHS Physician/ METASTATIC PROSTATE CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examir sician and burlel-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use es the burle Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day been signed by the s should be detached P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 HYPERTENSION Records, Completed 1 ☐ Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? CONGESTIVE HEART FAILURE 24a. Was an page 2 autopsy perform certificate 1 ☐ Yes 2 🗓 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien: of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🕅 Residence 6 🗆 Other (Specify) 1 Yes 2XXNo မှ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury Division s after death.

I Director: Aft in by the fur work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation М 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funerel I completely filled Medical 29a. Certifier 1 XX Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) D 57284 Konom, ne OCTOBER 15, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 GRACEFIELD RD., SILVER SPRING, MD

Registrar

ANNA B. KORZAN M.D.,

32. Regist ar's Sign

20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33636 State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year DEBRA LYNN 5:25 OCTOBER 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE MEDSTAR HOS PITAL CIT HAR3OR If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours Min. 221-52-6515 **Director** 1 🗆 M 2 🗓 F 53 Oct 25, Usual Residence of Decedent Mississippi 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? the Medical Examiner must be Funeral 23a 3906 Fairhaven Avenue #1 21226 USA items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. ō þ 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 ☐ No Specify. Maryland 21215-0036 If Yes, Give Year or Dates "natural", 3 ☐ Widowed 4 🔀 Divorced Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) cosmotologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jimmy Barfield Hamako Nakamura traumatic Department of Health and Important: If item 27 is n any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Kilbarger/sister 8019 Steeple Chase Ct Springfield, VA 22153 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) d S Was 21. Signature of Funeral Sec rector 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street whald Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. 21201 Interval Between Onset and Death Immediate Cause (Final Ph sician/ ADULT RESPERATORY disease or condition resulting in death) DESTRESS SYNDROM DAYS 14 Medical Due to (or as a consequence of) **Examiner** COMONTA DAYS Sequentially list conditions Examine cause (Disease or injury us to for as a consequence of death certificate be executed as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical P.O. Box 68760 nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 No Month Year Pregnant at time of death Dav Yes 9 Unknown The law requires that the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I s been signed be should be det 23e. Did tobacco use contribute to the cause of death? Completed by Records, AIDS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? SEPSIS 24a. Was an page 2 has performed 1 Yes 2 No Yes 2 No Division of Vital To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: ဂ္ 1 Yes 2 No s after deth.

I Direct r After this ced in by he funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou

To the Funer

completely fi 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ertifier 29d. Date signed (Month, Day, Year) OCTOBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TINEZ VARGAS 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

**BCT 1 9 201** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#14perFH, G933, 11,772012, WS
State of Manyland Department of Manyland

			For State of Mary				Mental Hy	giene	2010	00007	
			Registrar  1. Decedent's Name (First, Middle, Last)	Cer	tificate of L	<i>Jeath</i>	2. Date of Dea	Reg. No.	2012	1 0 0 0 0	
	Physicia		Hoan Cuong Do				Month 10	Day 17	Year 20 <b>1</b> 2	3. Time of Death 8:30 A M	
	Medi Examir		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of De			ounty of Death		
-2			Manor Care		8ethesda			Mo	Montgomery		
	Funeral	1		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 H Hours Mi			9. Birth Cour	place (State or Foreign	
	Director		216-94-5713 1 № M 2 ☐ F 63  Usual Residence of Decedent	Yrs.			9-10-194		Viet	**	
	land shov d at	힏	10a. State 10b. County 106	c. City, Town or Loc	cation					10d. Inside City Limits	
	Mary 28a-f otifie	Director		damstown						1 🗆 Yes 2 🗆 No	
	th the 3a or t be n	a D	10e. Street and Number		10f. Zip Code			0	of What Cou	ntry?	
	ath wi	Funeral	550D Young Family Trail East  11. Marital Status  12. Was Decedent Ever	- 110 I40 V	21710				States		
21215-0036	is filed within 72 hours after death with the Maryland tal Hygene.  Ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, 3 ☐ Widowed 4 ☒ Divorced  Year or Dates.	If	Vas Decedent of Hi Yes, specify Cuba Yes 2 🛣 No	n, Mexican, Pue	Specify Yes or No- erto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: Asian White		
15-	72 ho n "nai ledica	nple	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupa and of work done d	ation luring most of w	orking	16b. Kind	of Business/In	dustry	
12	within giene.	Cou	Elementary/Secondary (0-12) College (1-4 or 5+)	life. DO	O NOT use retired)			Retail	1		
bu	be filed v ental Hyg 'ked othe ic event,	Be	17. Father's Name (First, Middle, Last)		j	18. Mother's N	ame (First, Middle,	Maiden Surr	name)		
ylaı	ld be Ments arked atic e	으	Cu Do			Lang Tru	iong				
Mar	shound and 7 is m		19a. Informant's Name/Relationship (Type, Print)				Rural Route Number			Code)	
e,	age 1 and 2 should be file ant of Health and Mental F it: If item 27 is marked of y or other traumatic ever		Chan Cao - Daughter  20a. Method of Disposition			y Trail E	ast, Adamst				
Baltimore, Maryland	Page 1 nent of ant: If it ary or o		1 X Burial 2 Cremation 3 Removal from State		natory or other place	1 111/2	Date 16/2012		ion - City or To		
altir	# P E E		21. Signature of Funeral Service Licensee Edward Sage	National Me	Name and Addres					Virginia	
ä	permi Depar Impol any ir		Luward Jage	-		,	Rockville,		Goldberg nd 20852		
П			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ente	r the mode of dying	, such as cardia	ac or respiratory arr	est,		Approximate Interval Between	
V	h sician/		Immediate Cause (Final disease or condition	NEBRA	L VAJ	LULAR	2 ISCH	EMIA	4	Onset and Death	
1	Medical Examiner		resulting in death)  a. Due to (or as a con	nsequence of):							
		Jer	Sequentially list conditions, b. Due to or as a con-	ise vience ille					_		
4	ansit	amir	cause. Enter Underlying Cause (Disease or injury								
7/2	execu an an	EX	that initiated events c. Due to (or as a con	sequence of):		-					
09/	cate be executed physician and s the burial-transit	edical Examiner	d								
387	ertifica ding pl		IF FEMALE:			_					
Division of Vital Records, P.O. Box 68	In the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1	Fetal death 3	Ectopic pregnancy Other (specify)			23d.	. Date of delive Month	ery Day Year	
9.	s that gned to	by P	Part II. Other significant conditions contributing to death but no	t resulting in the un	nderlying cause give	en in Part I.	23e. Did to	bacco use c	ontribute to th	ne cause of death?	
ds,	equire sen si	ted					. 1 □ Y	es 2 N	lo 3 🗌 Prob	bably 4 🗆 Unknown	
Recor	rsician; The law re s certificate has be director, page 2 sh	Completed					24a. Was a autop: perfor	sy med?		psy findings available mpletion of cause of	
ta	ician; sertific ector,	Be	25. Was case referred to medical examiner? Hospital:			ce of Death (Ch	eck only one)				
> =	Phys this c	၉	1 Yes 2 No Hospital: 1 Inpatient 2  27. Manner of Death 28a. Date of injury	2 ER/Outpatient 28b. Time of		4 Nursing	Home 5 Resid			)	
o u	tth. : After e fune	cate	1 Natural 5 Pending (Month, Day, Yea 2 Accident Investigation		28c. Injury work? M 1 🗆 N	es 2□No	28d. Describe ho	w injury occ	curred		
isic	Atter er dea ector by th	Certificate:	3 Suicide 6 Could not be			20 20 110	28f. Location (St		mber or Rural	Route Number,	
<u>`</u>	rtal or rrs aftr al Dir		building, etc. (Spi				City or Town	,			
	Hosp 24 hou Funer stely fil	edical	29a. Certifier (Check 2 Medical Examiner: On the basis of examiner)	nation and/or investig	gation, in my opinior	<ol> <li>death occurred</li> </ol>	at the time date an	d place and	due to the car	ise(s) and manner stated	
	othe	Σ	only one) 3	t of my knowledge, o	death occurred at th	e time, date and	place, and due to th	e cause(s) ar	nd manner as s	stated.	
	-5-0		> Thou, u	14		5712			gned (Month, E	*	
	5	1	30. Name and address of person who completed cause of death (	(Item 23a) (Type, Pri	int)			(			
	٠. ر		Truong 8ou, MD - 10110 Molecular Dr.		ckville, Ma	ryland 20	0850				
	Stat Registra	_	31. Date filed (Month, Day, Year)  32. Registrar's Si	•			-				
	negistia	1	UCT 1 9 2012 /2 4	acked.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33638 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Tetobar LOIS KATHRYN DOUGHERTY 2353 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore Baltimore CIT N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) Director 241-44-2255 80 1 M 2 X F Yrs 10/16/1931 NC Usual Residence of Decedent 27 is marked other than "natural", or Itams 23a or 20a-f show traumatic event, the Modical Exterior mast be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director HARFORD MD FOREST HILL 1 No. 2 No. 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21050 281 TRUDY CT USA parmit. Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mantai Hygiena. Important: If Item 27 is marked other than "natural", or Items any injury or other traumatic event, the Medical Factorians. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ≥ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Specify: WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 MARY HOCKADAY MACK GARDNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1823 HAMLET PLACE NORTH BEL AIR, MD 21015 HELEN WHITE-DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 KBurial 2 Cremation 3 Removal from State LAKESIDE MEMORIAL 10/18/12 LILLINGTON, NC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BELAIR 50 MACPHAIL RD BEL AIR, W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition lostridium difficile colitis Physician Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi): baan signad by tha attanding physician and should ba datachad for usa as tha burlal-transit or Attanding Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Cther (specify) Month 9 Unknown P.0. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 숩 disease 1 yes 2 No Records, Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attanding Physician: Tha law within 24 bours aftar death.

To the Funeral Director: Attanthis carificata has i completely filled in by the funeral director, page 2: autopsy perform 1 Yes 2 No Division of Vital 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 2 1 No 잍 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manny of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Cedificing Norse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 15 V se of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore Kristine UMUT 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Will Edmondson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

MAK ONK		1- For State Criviaryland / Department of Health and Mental Hygiene Certificate of Death	2012 3363
Physici		Registrar  1. Decedent's Name (First, Middle, Last)  2. Date of Death Registrar	3. Time of Death
Medical Exam	ner	VV // September 2	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1800 block of Mosher Street Baltimore	4c. County of Death
Funeral			MM/DD/YYYY 9. Birthplace (State or
Director		218-92-9520 12M 2 F 35 Yrs. Months Days Hours Min. Aug 3	30 977 Foreign Country)
, fr		Usual Residence of Decedent  10a. State 10b. County 10c, City, Town or Location	10d. Inside City Limits
d now any		100 D 1/10 D - 2T	1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Code 10g. (	Citizen of What Country?
5-0036 lied within 72 hours after death with the Maryland Hygiene. I other than "natural", or items 23a or 28a-f shother the Medical Examiner must be notified at once.			LS.A.
th with tems 2.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
ter dea			Specify: Rlack
ours af atural	d by	o Tor Dates:	bb. Kind of Business/Industry
36 n 72 h nan "n ical E	olete	Elementary/Secondary (0-12) College (1-4 or 5+)  Wo We	11/12
-003 d withi giene. ther th	Completed	17, Father's Name (First, Middle, Last)	den Surname)
21215-0036 wild be filed within 7 Mental Hygiene. marked other than e event, the Medica	Be		Edwards
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-faho or other traumatie event, the Medical Examiner must be notified at once	ဥ	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number,	21 1 1 1 1
i, MD and 2 sho ealth and tem 27 is		Congela Committee - Springer	Oc. Location - City or Town, State
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is us injury or other traumatic.		1 Donation 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Co dar 14.11 Cemetery Ct12, 2012	Stenn Burnie. MD
Baltin permit. Pa Departmen Importan injury or		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Physics of Funeral Service Licensee	Temporal Com
Per Per M		John Co Suym 230 Pest Auton Pers	2 Bold 700 2 229
Physician	V 10	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line.	shock, or heart Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	Deaul
		Sequentially list conditions, b.	
	ine	if any, leading to immediate Due to (or as a consequence of):	0.
No s	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
60, tte be executed hysician and e burial - transit			
60, ate be ex hysician ne burial		IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
Sox 6876 leath certificat e attending ph for use as the	jan/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy	Month Day Year
Box 687 e death certific the attending r ed for use as th	Physician/I	1 Yes 2 No 9 Unknown 9 Unknown	
that the ned by the detache	by Pr		cco use contribute to the cause of death?
of Vital Records, P.O. ag Physician: The law requires that the After this certificate has been signed by inneral director, page 2 should be detach			2 No 3 Probably 4 Unknown
cords, law requii has been s	Completed	autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
Rec: The I			
Vital   ysician: his certifi director.	o Be	examiner?   Hospital: 4   Leading of TRYOLDER OF TOO HOLDER OF TOO	sidence 6 Other: Scene
n of \ding Phy.	-1	27 Manner of Death 28a Date of Jointy 28h Time of Jointy 28c Jointy at Work? 28d Describe hour	injury occurred
sion ttendi death. ctor:	atio	1 Natural 5 Pending Pound: FOUND: Subject shot Subject sh	
Division tal or Attendi rs after death al Director: A	Certification:	3 Suicide 6 Could not be determined (Specify) Local Street (Specify) Local Street	et and Number or Rural Route Number, City  ) sher Street, Baltimore , MD
Division of Vital Records, P.O. Box 687( To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the			
To the Inthin 2 to the Into the Inthin 2	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and and manner stated.	
F S F S	ž		9d. Date signed (Month, Day, Year)
3 m		throe made i	eptember 25, 2012
28.		30. Name and address of person who completed cause of death (Item 23a)  Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
Regist	rar	1 UC 19 2012 Burner & Sacret	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33640 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month O 6 201 1040A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner University of Maryland Medical Center
5. Social Security Number 6. Sex 7. Age (In vrs. last bir N Bostimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign **Funeral** Months Hours Min. 76 215-32-1087 **Director** 8-29-1936 VIRGINIA Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director BALTIMORE WHITE MARSH MD 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral U.S.A. 21162 5813 LYTLE ROAD items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11 Marital Status Race - American Indian. Armed Forces?

1 Yes 2 X No Black White etc. þ 1 Never Married 2 Married 72 hours after ō Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: WHITE 'natural", 3 Widowed 4 Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) 11 AUTOMOBILES MECHANIC Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file.
Department of Health and Mental I.
Important: If item 27 is marked any injury or other. 18. Mother's Name (First, Middle, Maiden Surname) ည SOURS ELLIS MARY GILBERT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ELIZABETH ELLIS/WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State HOLLY HILL MEMORIAL 10-20-12 MIDDLE RIVER, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21237 1211 CHESACO AVE ROSEDALE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ an digou/monary disease or condition Medical resulting in death) Examiner APPROVED BY MESSE Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events CERTIFIC resulting in death) Last Physician/Medical death certificate be Box 68760 ding p IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ jo in the past 12 months? Pregnant at time of death ed by the at detached for Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas 1 Yes 2 No 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, e Hospital or Attending Phys 24 hours after death.
Funeral Director: After this letely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at Mechanical Fall due to 1 🗌 Matural 5 Pending 2 Accident 1 Yes Investigation Parkinsons Disease 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etg. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 58/3 Lyrre Road 4 Homicide determined White Marsh, MB 2116 Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 102296 2012

Registrar

DHMH 17 Rev 06-2011

30. Name and address

31. Date filed (Month, Day,

22 South Greene street. Battimore MD

person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Brenda Lee Forsythe aoia 1829 M ΪO 12 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Baltimore Washington Medical Center Burnie en Inne 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Days Hours Director 217-58-2129 1 □ M 2 🔏 F Usual Residence of Deceden 59 May 11 Maryland or 28a-f shov 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 X No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 312 Lori Drive #F 21061 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. ò Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 21215-0036 2 No 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7's Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) 12 cashier Be Baltimore, 'Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ <u>ldwin Jack Bennett</u> Doris Jean Talkington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bill Bennett/brother 18 Sumac Road Glen Burnie, MD21060 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State any injury or 4 Donation 5 Other (Specify) meral So 22. Name and Address of Facility
State Anatomy Board Ronald 655W. Baltimore Street Baltimore, MĎ 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ etastatic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, reading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy 1 ☐ Yes 2 ☐ No ☐ Yes 2 🛛 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 12 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 🗌 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier me and address of person who completed cause of death (Item 23a) (Type, Print) ominial 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ward 12:10 AM 12 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore och Social Security Numbe 8. Date of Birth (Month, Day, Aug • 18 **Funeral** 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Days Country) Maryland 1 X M 2 D F Min. Hours 212-32-8797 Director 77 Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Marvland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 625 Stone Mill Court 21009 USA death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black. White, etc. 0 1 Never Married 2 Married þ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2X No Specify: "natural" Completed Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Buyer Health & Beauty Aids other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Edward Field Sr. Anna Josephine Gibbons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce V. Field / Wife Page 1 and 2 Stone Mill Court, Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Burial 2 ☐ Cremation 3 ☐ Rem mportant If injury or val from State Crownsville VA Cem. Donation 5 Other (Specify) 10-23-12 Crownsville, Maryland 22 Name and Address of Facility McComas Funeral Home, 1317 Cokesbury Road, 21. Signature of Funer any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cancer inny Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami that the death certificate be executed the bunal-transi Due to (or as a consequence of) Physician/Medical Box 68760 se as t IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Yunknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy performed? Yes 2 No death? 1 Yes 2 No Yes the Hospital or Attending Physician: of Vital 25. Was case referred to medical Be filled in by the funeral director, 26. Place of Death (Check only one) Other: 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division after death. 1 Tes 2 🗌 No Accident Suicide Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 - Homicide determined City or Town, State Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 34359 (0/10) and address of person who completed cause of death (Item 23a) (Type, Print) Boulevard, Baltimore, Maryland 21218 3900 Loc4 Kaven m. 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Flury Lorraine Gertrude 0ct 20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1616 Prindle Drive Bel Air Harford Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Hours Min. **Director** 220-34-5255 1 N 2 D F 76 April 29,1936 Maryland ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director MD Harford 1 Yes 2 X No Bel Air 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1616 Prindle Drive 21015 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3X☐ Widowed 4 ☐ Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Optician Optical Company Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumate. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Charles G. Tillman Theresa Springman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1616 Prindle Drive Patricia Saneman (Daughter) Bel Air, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Sacred Ht. of Jesus Gem.10/19/2012 Dundalk, Maryland Fisher Thatles 22. Name and Address of Facility Signature of Funeral Service Lices Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Friysician/ ISE ASE Liver disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): a Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
2 hours after death.
5 Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 1 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? é Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 2 **I** No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manny of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 30. Name and address of person who se of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

9 2012

32. Regist

			For State Registrar	Pleas			in Black In yland / Dep <i>Ce</i>		Health and			9	2261.1	
55	Physici /Medi		1. Decedent's Name Carolyn	S. Gle	edhill						r 1 <sup>2</sup> 7	ZU Z 2012"	3. The foats 10:30 Am	
	Examir	ner	4a. Facility Name (If r	ood Nu	give street and nu csing Hon	mber) <b>E</b>		Rockvil				ntgomery		
÷	Funeral Director		5. Social Security Nur 087–14–726	61	6. Sex 1 ☐ M 2 🔀 F	7. Age	(In yrs. last birthday, 89 Yrs.	If Under 1 Year Months Days		8. Date of B	irth ay, Yaar 9	23 Main	place (State or Foreign intry)	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medital Examiner must be notified at once.	ector		10b. County Montgor	mery		Oc. City, Town or L				10g Cit		1 XYes 2 □ No	
	ath with 23a or ust be	Funeral Director	1104 Carna					20850			USA			
920	ours after der al", or items Examiner m	þ	11. Marital Status  1 ☐ Never Marrie  3 ☐ Widowed 4		If Yes, G	orces? 2 ⊟ No		If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☐ Wo Specify:				14. Race - American Indian Black, White, etc. Specify: White		
21215-0036	within 72 ho iene. 'than "natui the Medical	Completed	(Specify Elementary/Second		t grade completed,	1-4or 5+)	(Give	_	pation e during most of wor ed)	rking	Montgomery  th 137, Year 23  P. Birthplace (State or Foreign Malfie)  10d. Inside City Limits  1			
Maryland 2	ould be filed Mental Hygi arked other atic event, t	To Be Co	17. Father's Name (FELwyn E. S		.ast)				18. Mother's Nar Isabelle		e, Maider			
	nd 2 sho alth and 27 is ma r trauma		19a. Informant's Nan James H. (	ne/Relationsh Gledhi	<sup>ip (Type. Print)</sup> L1/husbar	nd							p Code)	
Baltimore,	Pages 1 al nent of Hes int: If Item iry or othe		20a. Method of Dispo 1 Burial 2X 4 Donation 5	Cremation	3 □Removal from	State	20b. Place of Disp cemetery, cre Final Jou	osition (Name of matory or other pla rney Cre	matory 10	Date 0/19/12		•		
Balti	permit. Departr Imports any Inju		21. Signature of Fund	& L	Hell	k	MO1251 E	everly L	. Heckrot	te, P.A	. Cl			
68760,	Physician and bulkarian and street personned bulkarian street bulkarian st	dical Examiner	Immediate Cause (Fi disease or condition resulting in death)  Sequentially list condition of any, leading to immediate or cause. Enter Underly Cause (Disease or in that initiated events resulting in death) La	ditions, nediate ying	a. Pneum Due to  b. Due to	onia (orasa (orasa							Onset and Death	
P.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 D 9 ☐ Unknown			birth 2 nant at ti	Fetal death 3	∃Ectopic pregnand ∃Other (specify) _	су				,	
Records, F	w requires tha been signed should be det	by	Part II. Other signific	ant conditio	ns contributing to o	leath but	not resulting in the ι	nderlying cause gi	ven in Part I.					
al Rec		Completed								24a. Wa aut per 1∐ Yes	opsy formed?	prior to co death?	ompletion of cause of	
Vital	Physician: Th r this certificate ral director, pag	o Be	25. Was case referre examiner? 1 ☐ Yes 2 ☐ KN		Hospital:	Innationt	2 ☐ ER/Outpatie	ot 3D DOA Ot	26. Place of Dea			6 DOther (0	74. A	
sion or	ding J. After fune	$\vdash$	27. Manner of Death 1	5 ☐ Pending investiga	28a. Date (Moi		28b. Time of	f 28c. Inju	47.2 Nursing r	28d. Describe			ny)	
Division	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ned 28e. Plac build	ling, etc.				City or To	own, State	e)	raí Route Number,	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical	29a. Certifier 1 (Check only one)	☐ Certifying	xaminer: On the l	e best of pasis of e iner state	my knowledge, dea xamination and/or indo.	h occurred at the to exit yestigation, in my	time, date and place opinion, death occ	e, and due to th urred at the time	e cause(s e, date an	and manner as d place, and due	stated. to the cause(s)	
	Z M	M	29b. Signature and ti	ne	v d	Du	llan	D382				ober 17,		
_	6,01		30. Name and address Anurita Me	endhira	atta, M.D	. 90	43 Shady	*	. Gaither	sburg,	MD 2	0877		
	Sta Registi	ar	31. Date filed (Month	, Day, Year)	32.	Pegistrar'	s Signature							
DH	MH 17 Rev 1/2	001			,									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 7 October 20°72 John F. Gahan 12:30PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Cromwell Nursing Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day Year) | 9 2 2 9. Birthplace (State or Foreign Country) MD 5. Social Security Number 215-16-1142 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Yrs. Director 89 Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f s any injury or other traumatic event, the Medical Examiner must be notified MD Baltimore Essex 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 USA 131 Wiltshire Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: imore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SS Admimistration Computer Programmer 9th Be 17. Father's Name (First, Middle,"Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James P. Gahan Geneive Shipley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 141 Wiltshire Road Baltimore MD 21221 MIchael Gahan /son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Bayview Crematory 10/22/12 Baltimore MD 4 ☐ Domation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Examiner carrier of Right 0901 Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine ysician and e burial-transit Cause (Disease or linjury that initiated events requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760€ the phy attending | IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death the ed by t detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed obstructive pulmonar 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an cate has page 2 s autopsy perform certificate vision of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury Natural Natural work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Title of sertifier only one)

State Registrar 29b. Signatu

completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Emge Rd, Baltimure, MD 21234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 25, 27, 28a-f, per me, g932 10-19-12 SM

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPT. 2012 ROBINSON GARY 5:05 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6105 HILLMEADE ROAD PRINCE GEORGE'S BOWIE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Sex 1 🛣 M 2 🗆 F 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** AUG. 4, 1931 Months Days Hours Min. MISSISSIPPI Yrs Director 427-52-3094 81 Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 No MD PRINCE GEORGE'S BOWIE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6105 HILLMEADE ROAD 20720 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces

1 XYes 2 If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 XMarried 2 No Maryland 21215-0036 1953 1 ☐ Yes 2X No Specify BLACK "natural", 3 Widowed 4 Divorced Specify: Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Snows - n and Mental Hygiene.

27 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE 12TH 2+ DATA COMMUNICATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ROBINSON GARY SR. BESSIE COLE other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health a REGINA GARY/WIFE 6105 HILLMEADE RD. BOWIE, MD 20720 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State injury or Department Important: If any injury or once. RESURRECTION CEMETERY 09-21-2012 CLINTON, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME, INC. 21. Signature of Fureral Service Licensee shula 7474 LANDOVER RD. HYATTSVILLE, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Annroximate Interval Between Onset and Death Immediate Cause (Final Physician/ SUBDURAL HEMATOMA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SETTERCATION APPROVED BY MEDICAL EXAMINER DEEP VENOUS THROMBOSIS Sequentially list conditions, Examiner if any, leading to minisulate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of, and -tran Due to (or as a consequence of) resulting in death) Last burial physician s the burial Physician/Medical #23,4工 代水やパと Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Pregnant at time of death 2 No 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 2 X No Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 X Yes 2X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) 27. Manner of Death 28b. Time of injury 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending Subject Fell on stairs 1 ☐ Yes 2 🕱 No Accident unknown<sup>M</sup> Investigation April,2012 Director: 6 Could not be Suicide 28f. Location (Street and Number of Rural Route Number, City or Town, State) 6105 Hillmeade Rd. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Hospital or within 24 hours a

To the Funeral D Home Bowie, Maryland Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 29d. Date signed (Month. Day, Year) D46591 SEPTEMBER 18, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ACHUFUSI NDUBUISI 7300 HANOVER DRIVE #103 GREENBELT, MD 20770 31. Date filed (Month, Day, Year State 19

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 33647 State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 14, Physician/ Gaff Charles Martin October 2012 9:10 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1544 Williams St. Baltimore City Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Min **Director** 216-52-5122 1 X M 2 □ F 60 June 25, 1952 Maryland or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD 1 X Yes 2 ☐ No Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1544 Williams St. 21230 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 X Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 1976-83 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) Medical Sales Nuclear Repair Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ å Adalaid Schaffer Gaff Genevieve Charles Andrew other traumatic plnous permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia A. Heier / Sister 25140 Indian Branch Rd., Millsboro, DE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4XXDonation 5 Other (Specify) Uniformed Sers. Univ.: 10/18/2012 Bethesda, MD 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death
13 MONTHS Physician/ METASTATIC NON-SMALL CELL LUNG CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ been signed by the atter should be detached for in the past 12 months?
1 Yes 2 No The law requires that the death Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CORONARY ARTERY DISEASE tXXYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has 1 Yes 2 No 1 ☐ Yes 2XXNo To the Hospitai or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified To the Funeral Director: After this certific completely filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) XX No Hospital: 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🖭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D51770 trahmerelle October 18 2012 04.01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 401 N., BROADWAY, WIENBERG BLDG. #1363, BALTIMORE, MD 21287 Access gistry Signeral

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Christopher Robin Gaul 18, 2012 October 3:45 Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1919 Old Turkey Point Rd. Baltimore Essex Social Security Numbe If Under 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year) 525 84 3780 72 **Director** 1 🖾 M 2 🗆 F May 16,1940 England 28a-f show 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Baltimore Essex 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be Funeral 23a 1919 Old Turkey Point Rd. 21221 USA "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. rmed Forces
Yes 2 Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes 2 2 7/1957 If Yes, Give 8727/1957 Year or Dates 8/26/1963 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Journalist News Broadcasting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Eric Gaul Mary Julia Winkel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Pamela D. Gaul (Wife) 1919 Old Turkey Point Rd. Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 10/22/2012 Baltimore, Maryland 22. Name and Address of Facility

Bruzdzinski Funeral Home\_P.A 21. Sign re of Funeral Service Lit ohn h Maryland 21221 <u>1407 Old Fastern Avenue Essex</u> 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final ce 11 Onset and eath Cancel Priysician/ disease or condition resulting in death) ea Medical Due to (or a a core sequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) Pregnant at time of death ed by the a g Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No 2 🗌 No 1 Yes director, 25. Was case referred to medical examiner?

1 Yes 2 X No Be 26. Place of Death (Check only one) Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 XNatural injury 5 Pending Accident
Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Funel

completely fi 29a. Certifier

the

2

State Registrar

(Check only one)

29b. Signature and title of certifier

DHMH 17 Rev 06-2011

mpleted cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Yela

Balto Md. 21237

0/2

29c. License number

Suite 208

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10b-f, perFH, G932, 10/19/2012, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 33649 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:07.M Medical not institution, give **Examiner** 4a. Facil 4b. City, Town, or Location of Death ountv\_of Death Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign **Funeral** Months Days Hours Min. **Director** Usual Residence of Decedent 10c. City, Town or Location

Glen Burnie or items 23a or 28a-f shov 10d. Inside City Limits any injury or other traumatic event, the Medical Examiner must be notified at Director Tes 2 X No eet and Numb 10f. Zip Code 10g. Citizen of What Country? 21226 109 Cherry Lane Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces' Black, White, etc. þ 1 Newer Married 2 Married 1 Yes : 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black "natural", 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
Te. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Be Pather's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) ည nformant's Na ne/Relations Addiess (Street and Number or Ru Method of Disposition 20b Date Signature of Funeral Service Licensee 22. Name and Add 1229 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pmysician disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Pregnant at time of death ed by the a detached f 9 Unknown Unknown P.O. signed k I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗆 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 🗌 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Marke Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october 13, 2012 James George Hollis 0605  $a^{M}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Year) 1919 London, England July 22, Days Hours Director 579-03-3616 1 M 2 D F 93 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "neturel", or items 23e or 28a-f show any injury or other traumetic event, the Marical Exercited must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 No Silver Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 3403 St. Leonards Court 20906 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 □ No
If Yes, Give WWII
Year or Date Korea 14 Race - American Indian. Black White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 ➡ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Private Law Firm 5+ Attorney Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alice Davidson William Stanley Hollis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14104 Chelmsford Road Rockville, MD 20853 19a. Informant's Name/Relationship (Type, Print) John D. Hollis/son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Final Journey Crematory 10/18/12 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice Going Home Cremation Service P.O. box 784 Clarksville MO1251 Beverly L Heckrotte, P.A Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsis Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Pneumoperitoneum Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit Clostridium Difficile Diarrhea or Attending Physicien: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day ☐ Yes 2 ☐ No g Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year, October 13, 2012 29c. License number 29b. Signature and title D67279 30. Name and address of person who completed dause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

19

Alagarsamy Veerappan, M.D. 1500 Forest Glen Road Silver, Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#8perFH, G934, 12/13/2012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Scrober 12 Carol Henry Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death DOCTORS Non Lan mm une 7 105 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Pay Hours Min. **Director** None 1 □ M 2**X** F 44 Oct. 12, 1967 United Kingdom Usual Residence of Decedent or 28a-f show 10a. State with the Maryland 10c. City, Town or Location be notified at 10d. Inside City Limits Director 1 Yes 2X No Birmingham Perry Barr 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 96 Davey Road United Kingdom items permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 ☐ Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Government 5+ Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clifton Uriah Henry Florence Tracey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sadie Cox/Aunt 10109 Dolby Ave. Glenn Dale, MD 20769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 St Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Handsworth Cemetery 11-05-2012 United Kingdom 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. Landover Road Hyattsville, MD 20785 7474 23a. Part 1. Either the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of leart failure. List only one cause on each line.

Immediate Cause (Final Arterios Leotte Hypertensive Heavil disease or condition Approximate Interval Between Onset and Death Physician/ Arteriosche Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immedicause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events physician and the burial-trans Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death been signed by the a should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? certificate 1 Yes 2 🗆 No Yes funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this a completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALVA don 31. Date filed (Month, Day, Yelai

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 20+2 Physician/ Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner BALTIMORE **ESSEX** 249 SANDHILL ROAD 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Davs Hours 215-18-9989 91 1 □ M 2 🕱 F Director 3-12-1921 MARYLAND 10d. Inside City Limits 10c. City, Town or Location 10a. State in then "neturel", or items 23e or 28e-f ebo the Medical Examiner must be notified at Director **ESSEX** 1 Yes 2 XNo BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21221 Funeral 249 SANDHILL ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?

1 Yes 2X No
If Yes, Give à 1 Never Married 2 Married ouid be flied within 72 hours after on Mentei Hygiene.

merked other then "neturel", or X Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) MONTGOMERY WARDS MANAGER 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pege 1 end 2 should be file Department of Health and Mentel h Importent: If Item 27 is merked of eny Injury or other treumetic ever onse. LYNCH HATTIE PARRISH CHARLES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 21237 ROSEDALE, MD 1613 BURNFIELD ROAD JANET LIMMER/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 10-20-12 BALTIMORE 4 Donation 5 Other (Specify) GARDENS OF FAITH 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME Signature of Funeral Service Licens 21237 1211 CHESACO AVE ROSEDALE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death END Stage Parkinsons Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exam After this certificete hes been signed by the attending physicien and infuneral director, page 2 should be deteched for use es the burial-trensit or Attending Physicien: The lew requires thet the deeth certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 26. Place of Death (Check only one) 25. Was case referred to medical 8 Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 1 No မှ 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 27. Manner of Death 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after deeth. E Funerel Director: Af eletely filled in by the fu Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar

To the Hoep within 24 hou To the Funel completely fi

29a. Certifie

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NSRAJAPAKSC

9 2012

Marley apalal mo

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28355mim m

5703

2 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Hawkins 2012 Oct. 8:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ship briend Baltimore Co. Middle River Social Security Number If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) Director 1 - M 2XX F 215-46-7551 Yrs 65 Feb. 21,1947 Maryland Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours efter death with the Maryland Director Middle River MD Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 705 Shipfriend Road 21220 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🛣 No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 end 2 should be filed within 72 h
Department of Heelth and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Mades
once. 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 12 Years Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arlene R. Livermore Kalvin B. Otto 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
705 Shipfriend Road Middle River, MD 21220 19a. Informant's Name/Relationship (Type, Print) Stacey J. Hawkins (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 😾 Cremation 3 🗌 Removal from State Hilltop Service Corp. 10/17/2012 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of the al Service Licensee Michael Neiser <sup>22</sup> Name and Address of Facility al Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death ₽nysician/ ASCUD disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and ifor use as the burlal-transit Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No signed by the at Id be detached for 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen renal Insufficence 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hronic cate has t autopsy After this certificate funeral director, pag 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending n 24 hours after death. ne Funerai Director: Aft inletely filled in by the fu work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

Registrar

Kenword

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

29c. License number

1295

10/14/12

21206

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dean Allan Hopkins 8:00AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Tate House - Hospice Of The Chesapeake Linthicum Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8 Date of Birth 9. Birthplace (State or Foreign Country)
Maryland (Month, Day, Year) 02/20/1960 Days **Director** 1 3M 2 D F 220-74-3701 52 Yrs 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryland Fleatth and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No MD Unkn. Unkn. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Unkn. Unkn Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education cify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12 Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Hopkins Frances Navlor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Ellen Hopkins / Mother 7603 Northwood Estates Court, Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State <u>≒</u> ፟ ፟ 4 Donation 5 Other (Specify) Chesapeake Crematory 10/16/2012 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1 Dorota Marshall Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) mos Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has I een signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: es, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Pregnant at time of death 1 ☐ Yes ∠ ∟ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \sum Residence 6 \times Other (Specification) 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural Natural 1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month C DSS AM Medical 4a. Facility Name (if not institution, give street and number Town, or Location of Death Examiner 4c. County of Death SALTIN BALTIM ORE HM If Under 24 Hrs. If Under Birthplace (State or Foreign Country) 6. Sex **Funeral** Age (In yrs. last birthday) 8. Date of Birth Min (Month, Day, Year) 8661 Director 1 M 2 D VA ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside Ofty Limits Director 1 Yes 2 No N/A Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21224 6112 Bessemer Ave. USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Yes Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Black "natural" 3 Widowed 4 Divorced Specify: Year or Dates ed other than "natu event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene Howard Uniform 11th Presser Be 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental F fitem 27 is marked or r other traumatic ever ပ္ Martha Veney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Natasha Harriston-Daughter 6112 Bessemer Ave.Baltimore, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of I-Important: If ite any injury or ot 1 Deurial 2 Cremation 3 Removal from State Trinity Cemetery 10/3/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) March F/H-East 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): use as the burial-transi Cause (Disease of injur that initiated events resulting in death) Last signed by the attending physician and does detached for use as the burial-tran Due to (or as a consequence of): The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed page 2 should peen s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 2 🗌 No 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 \sum Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SECOURS

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G932 10/25/2012 JH certificate of Death Reg. No. For State Registrar Decedent's Name (First Middle Last) 2. Date of Death Physician/ October Medical **Examiner** Location of Death TIMUVE If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Director 1 **№**M 2 🗆 F 10c. City, Town or Location or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County must be notified at Funeral Director 1 Yes 2 No 10g. Citizen of What Count Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubah, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces Completed by 1 Never Married 2 2 No ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 Black 1 Yes 2 No 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Be Father's Name (First, Middle, Last)
Willie Wilson မ 19a. Informant's Name/Relationship (Type, Print) HOOKINS 1605 Bruce 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State Department o Important; If any injury or once, ò 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Approximate Onset and Death Immediate Cause (Final Ph, sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Live Birth 2 Live Birth 2 Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) Month Unknown been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Director: After this certificate has autopsy perform death? Yes 25. Was case referred to m - ca Certificate: To Be 26. Place of Death (Check only one) examiner? Hospita Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. M nner Death 1 atural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check ertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) Mithe Julia State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0155 AM October 4a. Facility Name (ir not institution, give street and number) Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Samaritan Good Baltimore, MD Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foleign **Funeral** Months Days Min (Month, Day, Yea, 2/25/34 78 Director 216-30-6899 1 □ M 2 🔁 F MD Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore MD 1 X Yes 2 No 10f. Zip Code 21239 10e. Street and Number 10g. Citizen of What Country? Funeral 1246 Rossiter Ave - #2A USA Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married <u>۾</u> Maryland 21215-0036 African If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 KWidowed 4 Divorced Completed Amer 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Hospital Elementary/Secondary (0-12) College (1-4 or 5+) Dietary Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Jones Lavenia Jones 19a. Informant's Name/Relationship (Type, Print) Vernetta Rose/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1900 Hillenwood Rd, Balt., MD 21239 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Baltimore National 10/26/12 Baltimore, MD 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Hari P.Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Funeral Service License Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the diseas Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed ardu omu Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day 5 Other (specify) Pregnant at time of death ed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 🗌 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဍ ER/Outpatient 3 DOA To the Hospital or Attending Physisithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 1 Inpatient 2 Certificate: 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and add ss of person who completed cause of death (Item 23a) (Type, Print) nv 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar
DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>Day</sup>8, au OCTOBER 2012 5:44A M Ohnson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number Unk 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours Min. Country Director 1 M 2 □ F 77 Apr 25, 1935 Maryland or than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 31 Roosevelt Ave 21001 United States Apt. D1 12. Was Decedent Ever in U.S. Armed Forces?

1 Ares 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify. Year or Dates. 19 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Self-Employeed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ould be fill od Mental marked o ၉ permit. Page 1 and 2 should be Department of Health and Men Important: If Item 27 is marke any injury or other traumatic any injury or other traumatic once. Clarence Johnson Alma Woods 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stacey Johnson /Son 716 Wilmont St. Lenoir, NC 28645 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Removal from State 4 Donation 5 Other (Specify) Oct Beltsville, Maryland 2012 Chesapeake Cremator 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives MOISSS 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Colits s disease or condition Medical resulting in death) Examiner Tract Infection Unin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriar-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Pregnant at time of death Year ]Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial n'brillation 1 Yes 2 No 3 Probably 4 Hiknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2110 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifier 29d. Date signed 29c. License number (Month, Day, Year) D 62540 18/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shah 6101 Non Cha Street Ballimore filed (Month, Day, Yea 32. Registrar' Signatu 1 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33659 State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Year 10:40P M 2012 Richard Jones October 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4036 Hanson Oaks Drive Landover Prince George's 8. Date of Birth (Month, Day, **Funeral** Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Hours 1 **X** M 2 □ F Director 578-70-2752 59 July 30,1953 Washington, DC Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Prince George's Landover 10f. Zip Code 10g. Citizen of What Country? Funeral 4036 Hanson Oaks Drive 20784 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 XMarried Completed by 1 Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Entrepreneur 5+ æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Vonce Laura Jones 19a...Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 4036 Hanson Oaks Drive Landover, MD 20784 <u>Elaine Jones/Wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory 10/18/2012 Riverdale, Maryland 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. 21. Signature of Furteral Service Licer aphne 7474 Landover Road Hyattsville, MD 20785 23a. Part 1. Enler the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph\_sician/ Cardiac Dysrhythmia disease or condition Medical resulting in death) **Examiner** Stage Renal Diseas Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence or). Cause (Disease or linjury that initiated events burial-transi Diabetes and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ signed by the atte d be detached for in the past 12 months? Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autonsy death? 1 Yes 2 No Yes 2 V No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital မ 1 ☐ Yes 2 ☐XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 A Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 🛚 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director,

Medical (Check 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D29654 October 17, 2012 and address of person who completed cause of death (Item 23a) (Type, Print) Wendell McConnell MD 1221 Mercantile Lane Largo, Maryland 20774 Registrar's Signatu State

Registrar

Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical October 10:35 AM. 4a. Facility Name (if hot institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death TOIL Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Year If Under Months 1 M 2 F 216606616 Director 28a-f shov with the Maryland 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip 10g. Citizen of What Country? vortant: It item 2/ is marked other than "natural", or items 23a injury or other traumatic event, the Medical Examiner must be Funeral 5permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item any injury or other trainments. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give NHVC Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed 3 Widowed 4 Divorced Specify: 4 JAITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TOWIN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ SANDL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1749 OVERHILL RO GLEN & 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 10-15-12 21. Signat / of Fuy ral service Li FUNERAL 100942 23a. Part 1. Enter the disease aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or complications that shock, or heart failure Interval Between Immediate Cause (Final Onset and Death Physician/ 0 JY VY) disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence oi). attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? page 2 should be detached for Month Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1 Yes upleted filled in by the funeral director, To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: ျှ 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident after death. Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral E Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi License number M 2012 who completed cause of death (Item 23a) (Type, Print)

State Registrar

		- For	Plea	se Type or Po State of M							•	_	jible.			
Physiciar							ertifica IM	te of D	Death	Mo	te of Death	Day	0   2012	3 3 6 3. Time of Death	6 h M	
Medica Examina				give street and number, PKINS #05F					Location of D	eath		4c. County				
Funeral Director		5. Social Security No. 213–90–0  Usual Residence of	590	6. Sex 7. A		last birthday 87 Yrs.	) If Und Months	er 1 Year Days	If Under 24 Hours N	Hrs. 8. Dat Vin. (Mo <b>Ju</b>	te of Birth onth, Day, Ye ne 7, 1925	ear)	Cou	nplace (State or Fore ntry) prea	∌ign	
laryland 3a-f show ified at	Director	10a. State 10b. County  Maryland Baltimore			10c. Ci	ty, Town or I	Location	Balt	imore (	City				10d. Inside City Lim		
th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Di	10e. Street and Nun 11W 20th		Apt. 9I			10f. Z	ip Code 21	218		100		nited States of America			
ter dea	<u>ا</u> ک	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	12. Was Deceden Armed Forces ied 1  Yes 2 If Yes, Give Year or Dates.	?	S. 13			spanic Origin? n, Mexican, Po Specify:	? (Specify Yes uerto Rican, e	s or No- etc.)		ck, White	erican Indian, te, etc. <b>Korean</b>			
iin 72 hou ie. han "natu e Medical	Completed	(Spe	cify only highe	it's Education st grade completed) College (1-4 o	r 5+)	(Giv	DO NOT u	ork done d se retired)	luring most of	working	16		nd of Business/Industry			
e filed with Ital Hygier ed other t event, th	a l	17. Father's Name (i	First, Middle, L	ast)		<u> </u>		Homem	18. Mother's	Name (First,	Middle, Mai	Residence  Maiden Surname)				
2 should b th and Mer 27 is mark traumatic		19a. Informant's Na Jae Hwan				19b. Ma	illing Addre	ss (Street a eldst	unk. and Number of one Co	r Rural Route <b>urt</b> P	Number, Ci	ity or Town, State, Zip Code) n, Maryland 21120				
age 1 and lent of Heal nt: If item :		20a. Method of Disp	oosition  Cremation	3 ☐ Removal from Sta	te 20b.	Place of Dis cemetery, co vans Chape	position (Na	ame of	1	tober 2012	17,	c. Location	- City or		and	
permit. F Departm Importa any inju		21. Signature of Jul						red Addres		ives F	uneral	and C	rema	tion Ctr.		
e <u>ii</u> a e	ical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Approximate Interval Between Onset and Death  Due to (or as a consequence of):														
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   Unknown   Unknown   23c. If yes, outcome of pregnancy   23d. D   23d. D										1	ate of deli	e of delivery th Day Year		
w requires that the des s been signed by the 2 should be detached	Completed by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute 1										3 Pr	to the cause of death?  Probably 4 □ Unknown  autopsy findings available			
sician: The law is certificate has the large 2 sirector, page 2 s												No	death?	ompletion of cause		
Physicia r this cerl eral direct	e To Be	examiner? 1  Yes 2 a  27. Manner of Death	No h	28a. Date of ir	ijury	ER/Outpat		DOA Othe	4 L Nursi	ng Home 5				fy)		
Hospital or Attending Physician: 24 hours after death. Funeral Director. After this certificately filled in by the funeral director,	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Month, Day, Year) injury 28e. Place of Injury - At home, farm, so building, etc. (Specify)						work 1 🗆		28f. Lo	Describe how injury occurred  Location (Street and Number or Rural Route Number, City or Town, State)					
To the Hospital or A within 24 hours after To the Funeral Direc completely filled in b	Medical	(Check 2	Medical E	Physician: To the best xaminer: On the basis o Nurse Practitioner: To	examination	on and/or inv	estigation, i	n my opinic	on, death occur	rred at the tim	olace, and du	(s) and manner as stated.				
To the within To the comp	2	29b. Signature and			25	Pc. License	number		29d. Date signed (Month, Day, Year)  OCTOBER 15 2012							
3		30. Name and address  KAUSTUG  31. Date filed (Month	SHA P	who completed cause of	O OR	LEAN	e, Print) 5 57	REE	T BA	LTIMO	REMO	212	287			
State Registra			CT 19	2012	trar's Signa	ature	arke	/								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marquerite 8 ZOO FM ZÖIZ Medical 4a. Facility Name (if not institution, give street and Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE HOSPITAL ROSEDALL FRANKLIN SQUARE 5. Social Security Number If Under 1 Y If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 6-28-1917 Months 1 🗆 M 2 🔀 F Hours VIRGINIA Director 215-05-1664 95 Usual Residence of Decedent or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d, Inside City Limits traumatic event, the Medical Examiner must be notified at Director BALTIMORE ROSEDALE MD 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 1320 PINE GROVE AVENUE U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Completed by 1 Never Married 2 Married ☐ Yes 2X No 1 ☐ Yes 2 XNo Specify. If Yes, Give 3 X Widowed 4 Divorced WHITE Year or Dates Maryland 21215-00 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 WALTER BAUER RUTH WHITEHEAD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSEDALE, 21237 PATRICIA CRONE/DAUGHTER 1320 PINE GROVE AVE other 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition permit. Page 1 Department of Important: If it any injury or o 1 NBurial 2 Cremation 3 Removal from State GARDENS OF FAITH 10-22-12 BALTIMORE, 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ MODALY disease or condition resulting in death) Medical Due to (or as a consequence of Examine Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury g physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Year Pregnant at time of death 5 Other (specify) s been signed by the s should be detached 1 Yes 2 II 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? After this certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other. 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ္ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 24 hours after deatl Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Y

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, 6936, 2/19/2013, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1 N 2012 1:10 А м Mary Raisla Korzec Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 8ethesda Suburban Hospital 5. Social Security Number 7**420** 339-34-<del>7482</del> If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign) Days Hours Min. (Month, Day, Year) Director 1 M 2 TF 93 1~25-1919 Poland 10b. County death with the Maryland or then "naturel", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Silver Spring Montgomery 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States #602 20906 3310 N. Leisure World Blvd 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 ፟ No Specify: Specify: White Completed 3 Midowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sales 12 Be permit. Page 1 and 2 should be filed Deportment of Health and Mental Hy Importent: If Item 27 is marked oth eny injury or other treumetic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Golda Birkenwald Joseph Lieberman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7912 Springer Road., Bethesda, Maryland 20817 Grace F. Weissman - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removal from State Olney, Maryland Judean Memorial Gardens 10-14-2012 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service 21 22. Name and Address of Facility Edward Sagel Funeral Direction **Brad Smetzer** 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pulmonary Hypertension disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): lew requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☑ No the 9 Unknown o signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? σ. Completed by Records, 1 Probably 4 🖾 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2: autopsy Hospital or Attending Physicien: The 24 hours after death. performed? Yes 2 \( \) No After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🛛 No 1 🗌 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA Director: After thi 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 2 🗌 No 2 Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 10-12-2012 067986 1 20 80. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yureng Li, MO - 8600 Old Georgetown Road, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) OCT 1 9 2012 32. Registrar's Signature State Registrar

EC, MERY

N

KOR

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Morgan Ne'Cole King 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death TOPKIN 8. Date of Birth (Month) 13/2012 Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🗀 Min Maryland Maryland 0 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No N/A N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? N/A USA 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 X Never Married 2 Married 1 Yes 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Aaron King Nashelle Wesley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 Whitehall Circle, Elkton, MD 21921

22. Name and Address of Facility

10/17/2012

Maryland Cremation Services, PO Box 1413Baltimore, MD 21203

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year)

1800 Orleans St. Baltimore NO DUET

Beltsville, MD

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Physician/ Medical Examiner

For State Registrar

MD

Nashelle Wesley / Mother

4 Donation 5 Other (Specify)

Signature of Funeral Service License

Dorota Marshall

29b. Signature and title of certifier

Q. Name and address of person

20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

Physician/

Medical

**Examiner** 

**Funeral** 

Director

or 28a-f show

Director

Funeral

Completed by

Be

ပ

N/A

the Maryland

be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at

Examine signed by the attending physician d be detached for sice on the barrier Be Completed by Physician/Medical page 2 completely filled in by the funeral Medical Certificate:

To the Hospital or Attending Physician: The law requires that the death certificate be executed

has

After this certificate

within 24 hours after deatl To the Funeral Director.

Division of Vital Records, P.O. Box 68760

23a. Part 1. Enter the disease, or complishook, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	a. Extractions that caused the death. Do not enter the mode of dying, such as cardiac e cause on each line.  Due to (or as a consequence of):	or respiratory arrest,	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):		
Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1	1000	23d. Date of delivery Month Day Year
Part II. Other significant conditions cor	ntributing to death but not resulting in the underlying cause given in Part I.		o use contribute to the cause of death?
	24a. Was an autopsy performed?		
25. Was case referred to medical	26. Place of Death (Che	ck only one)	
examiner? 1 ☐ Yes 2 💢 No	ospital:  1  Inpatient 2  ER/Outpatient 3  DOA Other: 4  Nursing F	lome 5 Residence	6 ☐ Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)  28b. Time of injury 28c. Injury at work? 1  Yes 2 No	28d. Describe how inju	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Star	and Number or Rural Route Number, te)
(Check 2 Medical Examin	cian: To the best of my knowledge, death occurred at the time, date and place, er: On the basis of examination and/or investigation, in my opinion, death occurred Practitioner: To the best of my knowledge, death occurred at the time, date and process.	at the time, date and place	ce, and due to the cause(s) and manner stated

NP1 131 6236219

DHMH 17 Rev 06-2011

State Registrar who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33665 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Conradine H. Leyh October 76 2012 Physician/ 10:10p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Dundalk Heritage Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months July 19, 1917 213-05-6633 95 Director 1 □ M 2 🕱 F Usual Residence of De ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location Essex 10d. Inside City Limits with the Maryland Director MD Baltimore 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21221 8620 Kelso Drive by Funeral "natural", or items within 72 hours after death Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. 1 Yes 2X No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify White 3 Midowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than  $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ \textbf{12th} \end{array}$ College (1-4 or 5+) Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic ew ၉ Anna Marie Trager John Huber Sr. ab. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 853 Mildred Avenue Dundalk MD 2122 19a. Informant's Name/Relationship (Type, Print) 21225 Doris Huber /sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State oak Lawn Cemetery 10/19/12 P Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 Donation 5 Other (Specify) Balto. ML Zex 21221 Name and Address of Facility 300 MAce Ave. Balto Connelly Funeral Home of Essex 22. Name and Address of Facility f Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final Ph\_si\_ian/ disease or condition resulting in death) Medical Examiner usertially list non-difficing if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery Physician/ 23b. Was decedent pregnage 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 - Fetal death in the past 12 month Day Year Pregnant at time of death ed by the a 1 ☐ Yes ∠ ⊆ g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has performe 1 Yes 2 No 1 Yes 2 No 25. Was case referred to ical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this completely filled in by the funeral 28a. Date of injury (Month, Day, Year) of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Matural 5 Pendina death. 1 🗌 Yes 2 🗌 No Accident Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatur

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month LIVINGSTON OLIVA 6 A OCTOBER 01 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4800 4b. City, Town, or Location of Death 4c. County of Death are LOCHEARN leton MD 2121 B Baltmore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral**  Birthplace (State or Foreign Country) Days Min (Month, Day, Year) 214-24-2499 **Director** 1 □ M 2 🖒 F 99 May 25, | Hygiene. other then "naturel", or items 23e or 28a-f show vent, the Madical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 USA 3810 Ferndale Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: black 3 X Widowed 4 Divorced Specify. Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) unk unk housewife own home Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental h 7 is marked o treumatic. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3810 Ferndale Avenue Baltimore, MD 21207 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Importent: If Item 27 is any Injury or other treu once. DEnise Gregg/granddaughter 3810 Ferndale Avenue Baltimore, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in stat 21. Signatury of Funeral Service RO II a Ld 22, Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ₽nysician/ Dementio disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami signed by the attending physician and dbe detached for use as the buriel-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 ves, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) Day 9 🔲 Unknown Division of Vital Records, P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown speen si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No ည 1 Inpatient 2 ER/Outpatient 3 DOA : After this e funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident Investigation 1 Yes 2 No within 24 hours after death

To the Funeral Director: A
completely filled in by the f 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D 31464 10/1/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. EVITALO ST Soute 308 BALTIMORE MP 2/201 SITOAIIS A . HARKIMI MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 9 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month OCTUBER 524PM James Robert Latta Medical Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Baltimore Ugnes HUSDITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. (Month, Day, Year) Director 213-28-6327 1 **∑** M 2 □ F Apr 14, Maryland 81 parmit. Page 1 and 2 should be fliad within 72 hours after death with the Maryland Department of Health and Mantai Hyglena. Important: If Itam 27 is marked other than "natural", or items 23a or 28a-f show with injury or other traumatic svent, the Medical Examinational be notified at once. 10d Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director 1 X Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 USA 4230 Hollins Ferry Road #309 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Was Decedent 2. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: If Yes, Give Year or Dates Specify: White 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) construction drywaller 0 10 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Laura Bell Webb Walter Latta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1229 Guilford Road Glen Burnie, MD Denise Latta/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signal in of Funeral Service Licen. State Anatomy Board 655 W. Baltimore Street rector Baltimore. MD 21201 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death BOWEL Immediate Cause (Final LSCHEMIC Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attanding physician and I for usa as the burial-transit or Attending Physician: The law requires that the death cartificate be executed Cause (Disease of injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Day signed by the at Id ba datached fo 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown Completed baen sign 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this cartificate has I funeral director, page 2: autopsy 1 Yes 2 No óf Vital 25. Was case referred to medical 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this complately filled in by the funeral di 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending Division 1 ☐ Yes 2 ☐ No М Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Ž 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DU051865 ddress of person who completed cause of death (Item 23a) (Type, Print) MGN03

State Registrar 31. Date filed

900

URTIS

HALRS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30atePortMarylang? Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sctober Physician/ ANNIE CHRISTIAN MOCREA 0700 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SAMARITAN BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 223-68-3100 Director 1 M 2 KF 65 Yrs. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director MD BATIMORE 1X Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral The Alameda 21239 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. ۾ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: 3 - Widowed 4 - Divorced Specify: BLACK Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Authorizer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hellen WARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AVE. BALTIMORE, Md. 21212 DAUGHTER AUKER. 20b. Place of Disposition (Name of cemetery, crematory or other place)

Shiloh BAPT CHVRCH CEMETERY 20a. Method of Disposition 1 Burial 2 Cremation 3 A Removal from State 10/11/12 Reedsville, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VA UGHU GREENE FUNELAL SCKS Signature of Funeral Service Licens 4905 YORK ROAD. BALTIMORE, MO 21212 Approximate Interval Between Onset and Death Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physiclan and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IE EEMALE. 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pertension Completed 1 Yes 2 No 3 Probably 4 Tonknown 24b. Were autopsy findings available prior to completion of cause of death?
 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending hours after death. 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after dear To the Funeral Director completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00062689 Kathleen J She 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen L. Shaffer und 31. Date filed (Month, Day, Year) OCT 1 9 2012 State Registrar

			For	Please	State of M AMEND I	nt in larylan	Black Jr d / Depa	<b>1992</b> artme	gle Ink	Ens Health	ure A	II Copie	es Are /giene	Leg	jible.		
			State Registrar  1. Decedent's Name				'Čer	tifica	té of L	Death'		2. Date of De		. 21	0		3 5 6 5 me of Death
	Physicia Medic		20	SE F	1. mc	7					Month / o	Day	€	Year 2	10	MAGUE	
)	Examin	er	4a. Facility Name (if 4018 Br		4b. City	y, Town, or Ba	Location of	of Death		4c.	. County	of Deat	À				
	Funeral Director		5. Social Security No.	9586 6.5	Sex 1 □ M 2  F 7. Ag	e (In yrs. la	ast birthday) Yrs.	If Und Months	er 1 Year	If Under Hours		8. Date of Bi (Month, Di 02 02	irth ay Year) 1944	8_	9. Birt Cou	hplace (St	ate or Foreign
and	show d at	tor	Usual Residence of 10a. State	y, Town or Lo						•				de City Limits			
e Maryl	r 28a-f notifiec	Director	10e. Street and Nun	Balt		ip Code				10~ 0#	inon of 1	Mhat Ca		∯Yes 2 □ No			
n with th	is 23a o	Funeral	408 Brookhul Boad							4215			10g. Citizen of What Country?  USA				
be filed within 72 hours after death with the Maryland	and Mental Hygiene. is marked other than "natural", or items 23a or 28a-fs raumatic event, the Medical Examiner must be notified	þ	11. Marital Status  Never Marri  Widowed	Ever in U.S No	l l	f Yes, spe	edent of Hisecify Cubar	n, Mexicar	, Puerto	cify Yes or No Rican, etc.)		ck, White	erican Indian, te, etc.				
72 hour	"natu	Completed	(Spe	15. Decedent's l ecify only highest g				kind of w	ual Occupa ork done d se retired)	ation during mos	t of worki	ng		Industry			
within	/giene. ner thai t, the N		Elementary/Seco	. 1.			istar	nt		H	Care	9					
	and Mental Hygiene is marked other the aumatic event, the I	To Be	17. Father's Name	First, Middle, Last) Tam &	McKoy							ame (First, Middle, Maiden Surname) 10 Parke					
2 should	h and M 7 is mal traumat	- 9	19a. Informant's Na	ame/Relationship (	T1 - 1		1 /	·		and Numbe	er or Rura	Route Numb	er, City or	Town, S	State, Zip	Code)	15
1 and 2	of Health Fitem 27 other tra		20a. Method of Disp	position	18ister	20b. P	HOIE	sition (Na	ame of	76	[	Date WILL	20c. Lo	ocation -	- City or	Town, Sta	te
it. Page 1	モセラ .		4 Donation	5 Other (Spec	**	Fair Tha	nily P	eld	Distr	ict	11/	/25/2 <u>0</u> 1	22St	ind	in d	Jamai	.ca
permit.	Depar Impo any ir		21. Signature of Full	of C	isee S	1	22			erty	y Vai	ighn C	nda	ne f	WY6	rais 1 MD	21163
	ysician/ Medical		23a. Part 1. Ent or t shock, or hear Immediate Cause disease or condition resulting in death)	rt failure. List only Final	nplications that cause one cause on each lin-	е.		er the mo	de of dying	g, such as	cardiac c		arrest,			Appro: Interva	ximate al Between and Death 4-66 KJ
	xaminer		Sequentially list co	anditions	Due to (or as	a consequ	Jence ot):										
ted	Insit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Urisease or injury														
e be executed	ng physician and as the burial-transit	- 1	that initiated events c. resulting in death) Last Due to (or as a consequence of):														
e death certifical	within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medica	FFEMALE: 23c. If yes, outcome of pregnancy in the past 12 months? 1   Live Birth 2   Fetal death 3   Ectopic pregnancy   23d. Date of delivery   23d										Year				
s that th	gned by	by Pr	Part II. Other signif	icant conditions	contributing to death b	out not res	ulting in the u	ınderlying	g cause giv	en in Part	l.		e of death?				
require	been si should b	leted	1 L Yes 2 No 3 L F											Probably 4 Unknown			
The law	ate has page 2	Completed	autopsy pric performed? 1   Ves 2   No 1										death?	o completion of cause of			
sician;	s certific director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital:  1  Inpatient 2  ER/Outpatient 3							or.		ck only one)  Home 5   Residence 6 □ Other (Specify)					
nding Phy	ath. r: After this e funeral c		27. Manner of Death  1 Natural 2 Accident	28b. Time of injury		28c. Injury at work? 28d. Describe how injury of											
al or Atte	s after de	I Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determined				eet, facto	ry, office			28f. Location City or To	(Street and own, State)		er or Ru	ral Route i	Number,
Hospii	24 hour	Medical	(Check 2	Medical Exam	ysician: To the best of niner: On the basis of e	examination	n and/or inves	tigation, i	n my opinio	on, death of	ccurred at	the time, date	and place	, and du	e to the	cause(s) ar	nd manner stated.
To the	within <b>То the</b> сотр	2	29b. Signature and title of certifier  29c. License number										29d. Da	te signe	d (Month	n, Day, Yea	ar)
	1001		20. Name and addr	ress of person who	completed cause of c	leath (Item	23a) (Type, F	Print)		-13:				0,		6.	12
	00,		Cosmo	JACO	2	Li	henr	1 14	eig	Hin	A	12, 1	SALT	mi	on E	mg	21207
	Stat Registra		31. Date filed (Mont	n, Day, Year)	2. Registr	ar's Signat	har	2									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b perFH, G933, 1175/2012, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0948 AM RESTON 16 20 MELTON Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** BAUTIMORE MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours Director 1 **X**M 2 □ F 80 02/20/1932 ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director MD BALTIMORE 1 XYes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 30th 21218 USA STREE be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 11. Marital Status Black White etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 W No Specify: "natural", 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) CONSTRUCTION abover Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is many injury or other. 2 JAMES MELTON Funderburke DorA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20th ST. BATTIMORE, MD. 21218 BOYD DAUGHTER Antoinette 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State OWINGS MILLS, MD GARRISON FOREST 4 Donation 5 Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNERIAL SCUS 21. Signature of Funeral Service License BAYIMORE, MO 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. See S.

Due to lor as a consequence of): Approximate Interval Between Onset and Death Physician/ days Medical Due to for as a consequence of): Examiner Preumonio days 0 Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Take to for on a numerous or been signed by the attending physician and should be detached for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 1 Yes 2 L 9 Unknown a | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Disease Coronar 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes Medical Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l ; page 2 s autopsy perform 2 No Diabe 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \triangle \) Nursing Home 5 \( \triangle \) Residence 6 \( \triangle \) Other (Specify) Hospital 2 M No 1 🗌 Yes 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending iniury 2 Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Bi9916795 WID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD Meghan Che Union HOSP(+a) lemoria 31. Date filed (Month, Day, Year) State OCT 19 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 196, Physician/ 2012 Michaloski 8:400 M Joyce Medical 4c. County of Death Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Essex Rockaway Beach Avenue Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 10, 1932 Number 3 1 - 4 3 3 1 7. Age (In vrs. last birthday) **Funeral** Months Davs Hours 80 Director 1 □ M 2 🛛 F show 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. Count Director Essex MD Baltimore 1 ☐ Yes 2 No 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number 21221 USA Completed by Funeral 639 Rockaway Beach Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) own home Homemaker 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Norma West George S. Lynch ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Anthony Michaloski /husband 639 Rockaway Beach Avenue Balto. MD 21221 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Holly Hill Cemetery 10/20/12 Baltimore MD 22. Name and Address of Facility 300 Mace Ave. Balto. MD eral Service Licens Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final + months Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): 7 month **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760  $^{<}$ 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Month Day in the past 12 months?
1 Yes 2 No Pregnant at time of death the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed cate has to page 2 s 1 ☐ Yes 2 ☑ No Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To Nursing Home 5 Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director. After this completely filled in by the funeral director. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work' 1 Tes 2 No Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar 21244

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33672 1 - State Registra Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month PM M Christina S. McDonald October, 2012 7:35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2920 Chapel View Drive Silver Spring Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 577-78-4216 **Director** 1 □ M 2 🛣 F 58 Sept 20, 1954 Cuba Usual Residence of Deced items 23a or 28a-f show er must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2√ No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2920 Chapel View Drive 20904 USA . Was Decedent Ever in U.S. Armed Forces 2, 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian than "natural", or iter he Medical Examiner Black, White, etc. 1 Never Married 2 X Married þ within 72 hours after 1 X Yes 2 ☐ No Specify: 3 🗆 Widowed 4 🗆 Divorced Completed Year or Dates <u>hispanic</u> cuban unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) 27 is marked other the traumatic event, the cosmotologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ဂ Aldo Noel Santiesteban Celiana Cristina Milord and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health Gregory McDonald/spouse 2920 Chapel View Drive Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) e of Funeral Service Romand 22. Name and Address of Facility Wade State Anatomy Board 655 W. Baltimore Street Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ metastatic breast cancer Medical Due to (or as a consequence of): Examiner prior stage II breast cancer Sequentially list conditions, vears Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): for use as the burial-transit requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death Yes 1 ☐ Yes ∠ ☐ g ☐ Unknown Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page performed 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred injury X Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the full Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 💹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar 29b. Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Carolyn B. Wendricks

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

Division of Vital

29c. License number

D 37236

6410 Rockledge Dr Suite 506 Bethesda, MD 20817

29d. Date signed (Month. Dav. Year)

October 11, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9 11 15 16a&b 17 17&19a&b Per ANA BD G932 10/19/2012 JH State of Maryland / Department of Health and Mental Hygiene 20 17 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:30 PM McMillar Medical 10 2012 4a. Facility Name and not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Anversity Number Baltimore Medical (enter 9. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months (Month, Day, Year) **Director** 244-78-0533 1 □ M 2 🛛 F 63 June 18, 1949 North Carolina 28a-f show Examiner must be notified at 10a. State 10c. City. Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Baltimore 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3906 10th Street 21225 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by Black, White, etc 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give black 3 Widowed 4 X Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Clerical Health Dept. unk Be 17. Father's Name (First, Middle, Last) -unk 18. Mother's Name (First, Middle, Maiden Surname) -unk ည Collis McMillian Johncie Brock 19a. Informant's Name/Relationship (*Type, Print*) **Belinda Brink/daughter**<del>University of MD Med Ct</del> 19b. Mailing Address (Street and Number or Bural Route Number, City or Toyon, State, Zip Code)
1315 Hollins Street Baltimore, MD 21223
22 S. Greene Street Baltimore, MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ▼ Other (Specify) in state Signature of meral Sanying Onal 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Licensee S Wall Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, otherst failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fundamic SC Due to (Jas a consequence of): Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to himsediste cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be each hours after death.
 Funeral Director: After this certificate has been signed by the attending physicia. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy signed by the atte Month Pregnant at time of death Dav Year Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No After this certificate completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending work 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title

Registrar

State

parts

Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21 Mansox Manip Day, Year) UCT 1 9 2012 22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 17.2012 Donald O. McPhillimy P 3:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Genesis - Cromwell Center Parkville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** March Day 3 1 XM 2 | F Months Hours 1927 Maryland 212-20-4222 Yrs **Director** Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at **Funeral Director** Baltimore MD Baltimore 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 3401 Crosshill Court 21234 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 XMarried 1 ☐ Yes 2 🗷 No Specify: If Yes, Give Year or Dates white Specify: "natural" 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Independant Can Machinist 12 Company other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ၉ Lillian Garnetta Lopez James Thomas McPhillimy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 3401 Crosshill Court-Baltimore, Maryland 21234 Nancy McPhillimy-spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Dulaney Valley Memorial Gardens 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. 22, 2012 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 andra 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transi Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate 2 🗌 No Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

12-07844
----------

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Terry Jane Moris		S 1- For State Registrar	tate of Maryla		artment o rtificate o		nd Mer	ntal Hy	_	Reg. No	. 20	112	3367	
Physicia Medical Examir		1. Decedent's Name (First, Midd Terry Jane I	Morisi						2. Date of De Month October	Dav	Year		e of Death 59 <b>hrs</b>	
		4a. Facility Name (if not institution 1526 Parkland Drive	on, give street and nu	mber)		4b. City, Town, o Bel Air	or Location	of Death		4	c. County of D Harford	eath		
Funeral Director		5. Social Security Number 219–46–2422	6. Sex	7. Age (In yrs.	last birthday) Yrs	If Under 1 Ye Months Da		ler 24Hrs s Min.	8. Date of I	•		Birthplace oreign		
and f show any nece.	or	Usual Residence of Decedent  10a. State 10b. County  Maryland Hart		1 1	Town or Locat	ion							side City Limits Yes 2 X No	
h the Maryland 13a or 28a-f sho totified at once.	Director	10e. Street and Number 1526 Parkland		10f. Zip Code 210	15	-			Og. Citizen of What Country? United States					
fter death wit I", or items 2	Funeral	11. Marital Status 1 Never Married 2 N 3 XWidowed 4 Div	edent Ever in Unces? 2 X No		as Decedent of H	n, Puerto I			14. Race - A White, et	an, Black,				
5-0036 led within 72 hours a slygiene. other than "natura the Medical Examira	Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12			during m	it's Usual Occup ost of working lif	e. DO NOT				Kind of Busine			
21215-0036 uld be filed within 7 Mental Hygiene, marked other than		17. Father's Name (First, Middle			Kepre	sentativ	78.Mother	r's Name	(First, Middle		armacei Surname)	rricar		
2121 Ild be fi Mental marked event,	To Be	Allan Main De			19h Mailine	Address (Stre	Mary	y Jar	ne Cool	C mbor C	Situ or Town S	toto Zin Co	do)	
e, MD 21215-( 1 and 2 should be filed Health and Mental Hyg item 27 is marked oth		Merribeth Moris	1 (-27 ) /	ghter	11	allam Co							ae)	
늘 성성 보기		20a. Method of Disposition  1 Burial 2 Cremation	n 3 Removal fro	20b.	Place of Dispos crematory or of	ition (Name of c	emetery,		Date 22,		Location - Cit		state	
Baltimore, permit. Pages I a Department of He Important: If ite injury or other in		4 Donetion 5 XX Other S 21. Sign of Funeral Service	pecifiEntombme		ghview	Memoria]	L	2	012	Fa	llston,	, Mary	land_	
Bal Depar Impo		AN X-EL	aux (		Ev	ans Fune Newport	eral ( Drive	hape Fo	el & Cr prest H	cema Till	tion Se	rvice Land 2	s-BelAir 1050	
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	op gach line.			,						. 4-1	een Onset and	
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Mixed d Due to (or as a			ne and O	xycod	lone)	Intoxi	cat	ion		Death	
	Je l	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence o	of):					<u></u>		_		
· C- =	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence c	of):		_			_		=		
be executed sician and ourial - transit	edicalE	▼ UNPENDED	d	3a,27,2	8a-f - ne	r me,g9	33 11	-29-	12 gm	_		$\dashv$		
	/Med	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, o	utcome of preg					12 311	23	ld. Date of deli	very		
Box 6876C he death certificate the attending phys hed for use as the bh	Physician/M	past 12 months?	I I TIME DI	ant at time of de	ath -	tal death 3 her (Specify)	Ectopie	c pregnan	cy		Month	Day	Year	
ries that the signed by	ব	Part II. Other significant condit	ions contributing to	death but not r	esulting in the u	inderlying cause	given in Pa	art I.		_	use contribute			
Division of Vital Records, tal or Atteoding Physician: The law require rs after death.  al Director: After this certificate has been si led in by the funeral director, page 2 should be a proper at the funeral director, page 2 should be a proper at the funeral director, page 2 should be a proper at the funeral director, page 2 should be a proper at the funeral director, page 2 should be a proper at the funeral director, page 2 should be a proper at the funeral director and a proper at the	Completed									s an opsy formed?		to completio	dings available on of cause of	
tal Rection: The certificate ector, page		25. Was case referred to medica				26.Plac	e of Death	(Check or		2 <b>/</b> N	1	Yes	2 No	
'Vital   'hysician: r this certifi	P Be	examiner? 1 ✓ Yes 2 No		npatient 2	ER/Outpatient	3 DOA	Other <sub>4</sub>	Nursing	Home 5		ence 6 🗹 O	ther: Scene		
ion of teoding Ph.	Ë	27. Manner of Death  1 Natural 5 Pend	ding Fa 10	Day, Year)	28b. Time of I		uryatWork Yes 2. <b>★</b>	_			gested	medic	ations	
Division of Vital Records, P.O. Box To the Hospital or Atteoding Physician: The law requires that the death within 24 hours after death.  To the Fuoeral Director: After this certificate has been signed by the attended to the completely filled in by the funeral director, page 2 should be detached for u	Certification:	3 X Suicide 6 Coul			ome, farm, stree	et, factory, office	building, et		28f. Location or Town, Bel Ai	State) 1	.526 Pai	Rural Route	e Number, City	
To the Hos within 24 h	Medical (	29a. Certifier 1 Certifying Plone) 2 Medical Exa	hysician: To the best miner:On the basis o and manner st	f examination a	ge, death occur nd/or investigat	red at the time, o ion, in my opinio	date and pla n, death oc	ace, and o	lue to the cau the time, date	use(s) ar e and pla	nd manner as s ace, and due to	stated, o the cause(	s)	
(B)	ž	29b. Signature and title of certific	er	11	D		se number .M.E.				Date signed (		Year)	
HEND		30 Name and address of person Russell Alexander MD	Assistant M	edical Exam	niner 900	W. Baltimore	Street,	Baltimo	ore, MD 2	1223				
Sta Registr	ite	31. Date filed (Month, Day Year)	2012 32 Rec	gistrar's Signatu	ber	الما								

			For	State of M	laryland	d / Depa	artmen	t of H	ealth a	and M	lental Hy	gien	е				
		_	- State Registrar	ate of Death Re					eg. No. 2012 3367								
п	Physicia	n/	Decedent's Name (First, Mide	2. Date of Month						Day Y	ear	3. Time o	f Death				
	Medic	al .									OCTOBE	R 1	1,2012		1:50	<b>A.</b> <sup>M</sup>	
	Examin	er	4a. Facility Name (if not institution	4b. City,		Location of			4	c. County of							
No. of Street, or	Funeral		STELLA MARIS  5. Social Security Number		ge (In yrs. las	st birthday)	If Under		IMON]		8. Date of Bir	th		LTO.	ace (State o	or Foreign	
	Director		220-07-9840	1 □ M 2 <b>X</b> F	91	Yrs.	Months Days Hours			Min.	(Month, Da	y, Year)	Country)			o. 7 o. o.g.,	
	show		Usual Residence of Decedent		1						1-1-19	21_			LAND		
	Maryland	턍	The state of the s	ALTO.	10c. City,	Town or Loc								10	od. Inside C	ity Limits s 2 <b>X</b> No	
	the Maryli or 28a-f	Director	10e. Street and Number	АШО.	LTO. PARKY			Code			<del></del>	40 (	211 5148			s 2AL No	
	vith th			DI WA A Dr	ם מבתם							iug. C	. Citizen of What Country?				
	death with the Maryland ritems 23a or 28e-f sho ner must be notified at	Funeral	8820 WQALTHER  11. Marital Status	12. Was Decedent		13. V	Vas Deced	1234 ent of His	panic Orig	gin? (Spe	ecify Yes or No-		USA 14. Race -	America	n Indian		
21215-0036	ō ō E	ē	1 ☐ Never Married 2 ☐ M 3 🛣 Widowed 4 ☐ Divorce	If Van Cites	<b>K</b> No	l I	Yes, spec	ify Cuban	, Mexican	, Puerto	Rican, etc.)			Black, White, etc.			
5-0	2 hours aft "natural", dical Exa	Completed		lent's Education hest grade completed)	- 1	16a. Deced	ent's Usua			t of world		16b.	Kind of Busir	ness/Ind	ustry		
2	Z 88	Ē	Elementary/Secondary (0-12		5+)	life. Do	O NOT use	ırıng mosi	t or worki	ng							
2	a filed within tal Hygiane ed other the	0	12TH			SEC	RETAR						FICE COMPANIES				
anc	ild ba filed Mental Hy larked oth	TO B	17. Father's Name (First, Middle							e (First, Middle,		,	name)				
Ž	ould to		ROBERT C. B  19a. Informant's Name/Relation	EAN		401 14 %		L			TROSS:						
Maryland	2 shouth and the and t		THOMAS MARSA		son 19b. Mailir			•	na Numbe NDFIE				or Town, State, Zip Code) WIN, MD. 21013				
ē	1 and of Haa item othe		20a. Method of Disposition			ace of Dispo	sition (Nam	ne of			Date		Location - Ci			_	
<u> </u>	Page ment c ant: if		1 ☑ Buriat 2 ☐ Crematio 4 ☐ Domation 5 ☐ Other	n 3 🔲 Removal from State (Specify)	~	metery, cren DOWR I I	•	ther place		0-16	-2012	ELE	KRIDGE	. MD			
Baltimore,	parmit. Page 1 and 2 should be fi Department of Health and Mental Important: If Item 27 is marked any Injury or other traumatic ev once.		21. Signature of Funeral Service	Licensee					of Facilit	y SCE	IIMUNEK IOTTING	FU	NERAL I	HOME	, INC		
			23a. Part 1. Enter the disease,	or complications that cause	d the death.			-					, 110.		Approxima	te	
Z	Pnysician/ Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. CONGESTIVE HEART FAILURE  Due to (or as a consequence of):  Sequentially list conditions,  b.												Interval Bet Onset and	ween	
	Examiner																
	р #	Examiner	if any, leading to immediate Cause (Disease or injury	Due to (or as	a conseque	ence of):											
	ate ba axacuted Mysiclan and tha burial-transit	xau	Cause (Disease or injury that initiated events resulting in death) Last	c. ————————————————————————————————————	a concedua	ance off:							· <del>-</del>	-			
_	oa ax iclan burial	dical	resulting in death, Last	Duc to (of as	a conseque	ance on.											
760		w 1		d	-									上			
. Box 687	To the Hospital or Attanding Physician: The law requires that the death certificate be axecuted within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and compiately filled in by the funeral director, page 2 should be deteched for use as the burial-trans	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 124 No 9 ☐ Unknown	e of pregnand 2  Fetal at time of de	death 3 🗆	Ectopic p Other (sp					23d. Date Mont			•			
s, P.O.	res that the signed by do be deta	d by PI	Part II. Other significant condi	, o					sacco use contribute to the cause of death?								
ğ	raqui baan shoul	ete									24a. Was				sy findings		
ပို	e has	Ĕ									auto	DSV	prio	r to com th?	pletion of a	ause of	
<u>~</u>	an: Th tificat tor, pa	Be	25. Was case referred to medica	al	performed? death?  1  Yes 2 No 1 Yes 2 No 2 N									≥ No			
Vita	yslcla s cer dirac	일	examiner? 1  Yes 2  No	Hospital:	tient 2 🗆 E	R/Outpatien	t 3 🗆 DC	Other			me 5 🗆 Resi	dence	6 X Other 6	Specifyl	HOSP	[CE	
ð	Attanding Physician: or death. ector: Aftar this certific by tha funaral diractor.		27. Manner of Death 1 X Natural 5 ☐ Pend	28a. Date of inju	ury 2	28b. Time of injury		Bc. Injury work?	at		28d. Describe I			эрссиу	повг	LUL	
on	andir eath, or: Af tha fu	fica		stigation	-,,	,	М		∕es 2 🗌	No							
Division of Vital Records,	ital or Att irs aftar d al Direct lad in by	al Certificate:	4 Homicide deter	ne, farm, stre	e, farm, street, factory, office 28f. Location (St. City or Town						reet and Number or Rural Route Number, n, State)						
	To the Hospital or Attanding I within 24 hours aftar death. To the Funeral Director: Aftar complately filled in by the funer	Medical	(Check 2 Medica	ng Physician: To the best on Examiner: On the basis of the Nurse Practitioner: To the state of the Nurse Practitioner: To the state of the Practitioner: To the state of the Physician Republic of the P	examination a	and/or invest	gation, in n	ny opinion	, death oc	curred at	the time date a	and plac	e and due to	the caus	els) and ma	nner stated.	
	To the contract of the contrac		29b. Signature and title of certif	er Lecht	IRM	ρ	29c.	License I	number 30 <u>2</u>	72		29d. D	ate signed (M	fonth, D	20	2	
_	10V		30. Name and address of perso	RGAN, CRNP 2	death (Item 2 2 <b>300</b> D		•	LEY I	RD.	TIMO	NIUM, I	MD 2	21093	1			
· ·	Stat Registra	е ,	31. Date filed (Month, Day, Year)	2012 32. Registr	rar's Signatu	far	~										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
mend item 20b per fh 932 10-24-12 vt
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 18.15 MARSHALL M, MOSBY Medical 10 2012 12 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SAMARITAN HOSPITAL BALTIMORE HD 5000 If Under 1 Year | If Under 24 Hrs. Hours | Min. N/A Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 216-44-1325 Country) Director 1 M 2 D F 66 8/1/1946 MD r then "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21214 4817 Herring Run Drive USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 72 hours efter Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black Completed 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other then any Injury or other traumatic event, <u>the Me</u> Elementary/Secondary (0-12) College (1-4 or 5+) 12th All State Ins. Insurance Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugene Mosby Ethel Speed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Mosby-Wife 4817 Herring Run Dr. Baltimore, MD 21214 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Bayverer grematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Site Crematory 10/20/2012 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H-East 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) ANDXIC ENCEPHALOPATHY Medical Due to (or as a consequence of) Examiner HYPOTENSIVE SHOCK Sequentially list conditions, if any hading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or injury The law requires that the death certificate be executed GASTROINTESTINAL BLEEDING that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Dav been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≨</u> Completed HYPERTENSION, CVA- CEREBRO VASCULAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ACCIDENT tor: After this certificate has the funeral director, page 2: autopsy performed? 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ne Hospital or Attending Physic n 24 hours after death. Ne Funeral Director: After this of pletely filled in by the funeral dire Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) V.Manasa M.D. RESOOO 10/12/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL, BALTIMORE MANASA VULCHI GOOD SAHARITAN 31. Date filed (Month, Pay, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DRNG DANN .40 HM Medical not institution, give street and number) Examiner 4a. Facility Name (ii 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. Director 1 □ M 2 🔀 F 1948 03/04 MD28a-f show items 23a or 28a-f shoner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XVes 2 □ No MD Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 21239 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Medical Examiner Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc 0 Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", 3 ₩ Widowed 4 □ Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 l th and Mental Hygiene. ?7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Department of Health and Important: If item 27 is m. any injury or other traum? 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nelson 300 · BATTIMORE, MO. 21206 20a. Method of Disposition 20b. Place of Disposition (Name of pemetery, crematory or other pla 1 ABurial 2 Cremation 3 Removal from State Baltimore, Md 20 4 Donatio 5 Other (Specify) 21. Signature of neral S ice Licensee 22. Name and Address of Fecility NI0166 23a. Part 1. Enter the dise ions that caused the death. Do not enter shock, or heart failure. List only one Interval Between Onset and Death ause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? be detached for Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part LOther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DRESSION 1 Yes 2 No 3 Probably 4 Johnnown Completed 24a. Was an Were autopsy findings available page 2 prior to completion of cause of death? autopsy 1 \( \text{Yes} Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 20 No Other ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
2 Accident
3 Suicide work? 5 Pending 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 28595 sicell 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 1 ASNEEN () wings m11 1528

Registrar

Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year A M Lorraine Y. Pope 10 1517 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death )tospice at the Salisbury
If Under 1 Year If Under 24 Hrs. Wicomico Lake 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year) **Director** 218-34-9350 1 □ M 2 🗓 F Dec 23, 1937 Pennsylvania 74 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🖵 No MD Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 201 Federal Street #84 21601 USA items 2 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ō 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. laundry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sam Brobst Verda Ervin Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 9338 Mike Street Denton, MD 21629 Lisa Pope/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Sign of Funeral Servi 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Director Baltimore, Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ a. DOUAMOUS disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran Due to (or as a consequence of): physician Physician/Medical P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has ral director, page 2 autopsy performed' 2\ No 1 Yes funeral director, 25. Was case referred to .- dical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) n 24 hours after death.

• Funeral Director; After the pletely filled in by the funeral. Certificate: 28b. Time of 28c. Injury at 5 Pending Natural 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

To the F

completed Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

323

TERN SHORE DR, SALISBURY, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Month, Day, Year)

910

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death ecedent's Name (First, Middle, Last) 2. Date of Death Day 0 12012 Physician/ 7:070 October 16, Medical Facility Name (if not institution, give street and number) City, Town, or Location of Death Examiner 4c. County of Death DY 8/Date of Birth (Month /24/1969 9. Birthplace (State or Foreign Country) Orida Age (In vrs. last birthday) If Under 24 Hrs **Funeral** 1 🗆 M 2 🖰 F Min. 288-62-8506 43 Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 X Yes 2 □ No MD Baltimore Middle River ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a Funeral 1606 Burke Road 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 X Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 5+ the Information Technology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Gerald Plank Sharon Mazur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 Foxhunt Trail, Little Rock, AR 72227 Christopher L. Plank / Brother 27 Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 10/19/2012 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the diseas Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine Due to (or at a consequence of,: if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 1 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 \( \subseteq \text{Yes} \) Natural 5 Pending 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F WIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -tul-Rehman 1000 Orleans MD

DHMH 17 Rev 06-2011

State

Registrar

19

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2012 10:05 p.M Patrick Terence Regan Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 1904 Narrows Lane Silver Spring Montgomery Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 7. Age (In vrs. last birthday) Days Hours Min (Month, Day, Year) Director 1 👿 M 2 🗆 F 1933 United Kingdom 134-26-5951 Nov. 11, 78 Usual Residence of Decedent or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10h County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD 1 🗌 Yes 2 🔀 No Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 United States 1904 Narrows Lane filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Kor 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Korea 3 Divorced Specify: White Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Computers Systems Analyst Be permit. Page 1 and 2 should be filed Department of Heath and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Winifred Walker Michael Regan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jill Regan (wife) 1904 Narrows Lane, Silver Spring, Maryland 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct. Date 18 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State Beltsville, MD. 2012 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Signature of Funera Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani Lung Cancer disease or condition resulting in death) 10 months Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause Uisease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burlal-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🂢 Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law requires within 24 hours after death.
To the Funeral Director: After this certificate has been sig completely filled in by the funeral director, page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) October 16, 2012 D32407

139,04

State Registrar

DHMH 17 Rev 06-2011

M.D. 9707 Medical Center Dr. Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

Joseph M. Haggerty,

9 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012<sup>year</sup> October 9 6:20 PM M Mary E. Rowland Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Catonsville Baltimore Charlestown Retirement 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Yes July 25, **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 X F Hours North Carolina Director Yrs 79 238-54-5624 1933 Usual Residence of Deceden 28a-f shov 10a. State Hem 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Catonsville 10e. Street and Numbe 10g. Citizen of What Country? Funeral with 715 Maiden Choice Lane CR317 21228 USA death \ 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ð 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify white 3 Widowed 4 Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) education teacher should be filed with and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Maude Lillian Andrews Ray Albion Rowland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other Gladys Redner/sister 5008 Ellenwood Drive Greensboro, NC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) . Signa ure Funeral Service Name and Address of Facility
State Anatomy Board
Baltimore, MD 21201 655 W. Baltimore Street Baltimore, Enter the disease, or complications that caused the death, or heart failure. List only one cause on each line. Do not enter the mode of dving, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Causé (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (of as a consequence of). Examir executed and Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? signed by the a d be detached f Hnknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perforn death? certificate 1 ☐ Yes 2 ☐ No Yes 21-TNo 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home & Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State)

nours after death.

neral Director: After the filled in by the funeral within 24 hours a npleted f

> State Registrar

Medical

29a. Certifier

(Check

31. Date filed (Month, Day, Year, QCT 1 9 2012

3

29b. Signature and title of certifier

ar

and agaress of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

20040

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 33683 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** 16, 6:00 P Lucille October 2012 Elizabeth Riley /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner 3703 Swift Run Court Harford Abingdon Birthplece (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 200 F Yrs. 217-03-2333 June 18, 1920 Virginia 92 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County Item 27 is marked other than "natural", or Itams 23s or 28e-f show other treumatic event, its Medical Examinar must be redified at 1 Yes 2X No Maryland Abingdon Harford Direct 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 21009 3703 Swift Run Court filed within 72 hours after death v Hygiene. other than "natural", or Itams 239 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: 1 ☐ Yes 2 No þ White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 Homemaker permit. Pages 1 and 2 should be fitled Department of Health and Mental Hygi Importent: if item 27 is marked other any injury or other treumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Minnie Elizabeth Hubbard Arthur (nmn) Patrick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3703 Swift Run Court, Abingdon, Maryland 21009 Linda Baker / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Bel Air Memorial Gdn. 10/19/2012 Bel Air, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature Funeral Service Licenses 50 W. Broadway, Bel Air, Maryland 21014 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ALZHEIMER'S DEMENTIA Immediate Cause (Final OVERS YEARS **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Yes 2. No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? COLONARY KLTERY DISEASE 1 ☐ Yes 2 R No 3 ☐ Probably 4 ☐ Unknown Completed HUPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Tes 2 ₹No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 Yes 2 No funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 Natural 1 Tyes 2 No 2 Accident after death Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerel I 1 \*\*Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the of perturn Vol alar DØ016389 OCTOBER 17, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VALARAO H.D. 1716 HARPORD RASULOS FALLSTON (4D)21047 PERTECTO C. 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 1 1:25aM Medical 4a. Facility Name (if not institution, give street and number) Rity, Town, or Location of Death 4c. County of Death Examiner revesis Ballin Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex If Under 24 Hrs. **Funeral** Min. 1 □ M 2 💢 F Director or 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location must be notified at Completed by Funeral Director 1 🗆 Yes 2 🗙 No 10f. Zip Code 10g. Citizen of What Country? 23a 21234 SI jour 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) rral", or iten I Examiner n Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black 3 Widowed 4 Divorced Year or Dates It of Health and Mental Hygiene.

If item 27 is marked other than "nature or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Blade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore 12012 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Cacherna disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner the burial-tran Due to (or as a consequence of): attending physician for use as the burial Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: f yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death signed by the attendir 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b, Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 - Pending work after death. 1 Tes 2 No Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier October 16, 2012 alle Md 31. Date filed (Month, Day, Year, State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ October 12 2012 11:00P M Jay Steward, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard Lighthouse Senior Living Ellicott City Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 8. Date of Birth Min Mar 28 , **4925** 485-18-4193 1 🛣 M 2 🗆 F Director 87 28a-f show 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director 1 🗌 Yes 2 🔀 No MD Columbia Howard 0 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? 23a Funeral 21044 USA 6336 Cedar Lane ıral", or items ? I Examiner mus 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3x Widowed 4 ☐ Divorced Year or Dates. WWII of Health and Mental Hygiene.

Item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Defense Contractor Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Jay Steward, Sr. Rosemary Bergmier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Candace Hutcheson/daughter 9627 Morning Leap Terrace Columbia, MD 21046 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Final Journey Crematory 10/16/12 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD permit. Signature of Funeral Service Licer Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to in mediate cause. Enter Underlying Examine Due to for se a consequence of use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director: After this certificate has been signed by the attending physicial etely filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Telan Live Birth 2 Live Birth 2 Live Bregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Assith မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner/On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier October 16, 2013 WID who completed cause of death (Item 23a) (Type, Print) Colembia edan 31. Date filed (Mg Day, Year, State

DHMH 17 Rev 06-2011

Registrar

Division of Vital Records, P.O. Box 68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Europeal Director: After this certificate has been signed by the attending physician and

			Please	e Type or Pi	rint in I	Black Ir	ndelible Ink	k. Ensu	re A	II Copie	s Aı	re Legi	ble.	
		For State		State of N	/larylan		artment of H		nd N	fental Hy	/gier	ne		
		Registrar  1. Decedent's Name	o (First Middle 1	actl		Cer	tificate of D	eath			Reg. I	No. 9	115	1 33686
Physicia				•						2. Date of De Month Septemb		Day 22 2	Year 2012	3. The le D D D HHO (
Medic Examin		Theresa  4a. Facility Name (if		azal ve street and number,			4b. City, Town, or	Location of		Берсеш		4c. County of		2.43 AM
		1160 Dic		Road			Miller	rsvill	Le			Anne	Arur	nde1
Funeral Director		5. Social Security No. 217-58-1		Sex 7. A	ige (In yrs. la	ast birthday)	If Under 1 Year  Months Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Bir (Month, Da	rth ay, Yea <i>r</i>	r)	9. Birth	place (State or Foreign etry)
		Usual Residence		1 L M 24 F	61	Yrs.				DEc 3,	19	50	Mar	yland
/land f shov ed at	tor	10a. State	10b. County			y, Town or Lo								10d. Inside City Limits
e Man 28a- notifie	)irec	MD 10e. Street and Nur		Arundel	M	illers								1 Ves 2 No
be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	Funeral Director		icus Mil]	L Road			10f. Zip Code 211	.08			10g. (	Citizen of W USA	hat Cour	ntry?
eath v	Fune	11. Marital Status		12. Was Deceden			Vas Decedent of His	spanic Origi	n? (Spe	cify Yes or No-	-	14. Race	- Americ	can Indian,
fter d ", or i	þ		ried 2 Amarried	Armed Forces 1 Yes 2			f Yes, specify Cubar  ☐ Yes 2 💢 No		Puerto	Rican, etc.)		Specify:	k, White, wh	
ours a atural cal Ex	Completed	3 Widowed	4 ☐ Divorced  15. Decedent's	Year or Dates.			lent's Usual Occupa				1.0			
n 72 h in" na Medi	mp	(Spe	ecify only highest o		r.5.1)	(Give I	kind of work done d O NOT use retired)	uring most o	of worki	ng	166.	. Kind of Bus	siness/in	dustry
within yaiene re the the the the		12	oridary (0-12)	0	) O+)	cour	selor					healt	hcar	rė
e filed ntal Hy ed oth	To Be	17. Father's Name (	First, Middle, Last 'ranklin	•						e (First, Middle, Estelle		,		
ould b id Mer mark matic	_	19a. Informant's Na		-		10- 14-11-							-4- 7: /	D- /-)
12 sho alth an 27 is r trau			Salazar				g Address (Street a							,
of Hear of Hear fitem		20a. Method of Disp	position			lace of Dispo	sition (Name of natory or other place			Date		Location -		
Page ment rant: It		1 Donation	☐ Cremation 3 I	Removal from Sta	te C	ernerery, crem	latory or other place	6)						
permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once.		21. Signature of En	onald S	Made, Di	ector		Name and Addres ate Anato lltimore,		ard 2120		. Ва	altimo	re S	Street
	•	23a. Part 1. Enter t shock or hea	the disease, or court failure. List only	mplications that caus one cause on each li	ed the deat	h. Do not ente	er the mode of dying	g, such as c	ardiac c	or respiratory a	rrest,			Approximate Inferval Between
Physician/		Immediate Cause (		a	Met	astati	0 9/10	east		unce	~			Observation of the arm
Medical Examiner		resulting in death)		Due to (or a	s a consequ	ence of):								/
	ner	Sequentially list co	nmediate	b. Due to (or a	s a consequ	uence of):							-	
executed ian and urial-transit	Examiner	cause. Enter Under Cause (Disease or that initiated events	injury	C										
E 2 0 0	a E	resulting in death)		Due to (or a	s a consequ	uence of):								
ate be physic the b	edic		•	<b>d</b>										
certific nding l use as	Physician/Medic	IF FEMALE: 23b. Was decedent	pregnapt	23c. If yes, outcom								23d. Date	e of deliv	env
e atter	sicia	in the past 12 in the	months?	4 Pregnant	at time of o		Ectopic pregnance Other (specify)	У				Mon		Day Year
t the c by th	Phys	9 Unknown		9 Unknow		. 141 - 1 - 41	-1-1-1					<u> </u>		
s the	by	Part II. Other signif	ncant conditions	contributing to death	but not res	aiting in the a	ndenying cause giv	en in Part I.				1	7	ne cause of death?
/ requi	Completed									24a. Was				psy findings available
he law te has age 2	omp									auto perfe	psy ormed?	PI de	rior to co eath?	mpletion of cause of
ian: T artifica ctor, p	Be C	25. Was case referre examiner?	ed to medical				26. Pla	ace of Death	(Check	1 U Yes conly one)	2 1	MO]	☐ Yes	21,4110
hysic this ce al dire	ည	1 🗆 Yes 2 🖟	No			ER/Outpatien	t 3 DOA Othe	er: 4 🗌 Nur	sing Ho	me 5 Desi	idence	6 Other	r (Specify	)
ding F h. After f funer	ate	27. Manner of Death 1 D Natural	5 Pending	28a. Date of ir (Month, E		28b. Time of injury	28c. Injury work' M 1 🗆			28d. Describe	how inj	ury occurred	d	
Atten	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investigation 6 Could not determine	be 28e. Place of I	njury - At ho	me, farm, stre	eet, factory, office	162 2 🗆 1	10	28f. Location (	Street a	and Number	r or Rurai	Route Number,
rs afters all Direction		- Tomicide	determine	building,	etc. (Specify	)				City or To	wn, Sta	ate)		
Hospit 4 houn Funera tely fill	Medical	29a. Certifier 1 (Check 2	Certifying Ph	nysician: To the best	of my knowl	ledge, death on and/or invest	occurred at the time	, date and p	olace, a	nd due to the c	ause(s)	) and manne	er as stat	ed. use(s) and manner stated.
o the lithin 2 of the lomple	ž	only one) 3 29b. Signature and	Certifying Nu	rse Practitioner:	the best of n	ny knowledge,	death occurred at the	ne time, date	and pla	ice, and due to	the cau	use(s) and ma Date signed	anner as	stated.
2352		> 6	West	- di	A		1	200	91	{	250.1	1917	71	2
,		30. Name and addre	ess of person with	completed cause of	death (Item	23a) (Type, F	gint) // / C	Ī.	10	11 1		Vi	- "	2100
		5/10	M 4	rorbati	The	1141	1 000	livan	Ph	KIN	lug	Ole	n 1	U/n17,49
Stat Registra		31. Date filed (Mont	h, Day, Year)	32. Regi	trar's Signat	ture					,			1
negistra		OC1	1 9 201	- Denotia	A	Marie	90-	-						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ October 13. 2012 7:21 AM M Jean Schilling Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Harford Havre de Grace Harford Memorial Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days (Month Day, Yea Hours Min. Pennsylvania 1 □ M 2 🔯 ľ932 Yrs 80 Director 164-26-4664 Usual Residence of Decedent shov 10d. Inside City Limits 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County death with the Maryland Director 1 Yes 2 No MD Harford Havre de Grace 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21078 48 Locust Street USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. white 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12 0 apartment properties Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Charles Covolus Sallay Swatavage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franic Barton/friend 48 Locust Street Havre de Grace, MD 21078 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 

Burial 2 

Cremation 3 

Removal from State 4 X Donation 5 Other (Specify) on Euneral Service Licen Signati 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street i/rector 21201 Raltimore Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence or). Exami attending physician and for use as the burial-tran To the Hospital or Attending Physician: The law requires that the death certificate be exect Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Tetal death Ectopic pregnancy  $\square$  Other (specify) in the past 12 months? Month Day Year Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autope, performed: 1 Tes 2 No certificate Division of Vital 26. Place of Death (Check only one) director, 25. Was case referred to medical Be 1 Yes 힏 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After t iniury work?
1 Yes 2 No 1 🗷 Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide
Homicide within 24 hours after de To the Funeral Directo completed filled in by the 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the begrof my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of c 29d. Date signed (Month, Day), 30. Name and address of person who completed Herry Registrar's Sig 31. Date filed (Month, Day, Year)

State Registrar

amendase Type or Printin Black/Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 William Spurlock Oct. 5:23 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1780 Baltimore Dunda1k Stokesly Road Social Security Number 5935 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Min. Hours Director 230-28 1 XM 2 | F 86 Sept.16,1926 Virginia Usual Residence of Deceder item 27 is merked other then "netural", or items 23e or 28e-f shov other treumetic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 X No Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 1780 Stokesly Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. Completed by 1 Never Married 2 X Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Heelih and Mentel Hygiene. Important: If Item 27 is merked other then 'i any injury or other treumetic event, Item Mentel any injury or other treumetic event, Item Mentel any injury or other treumetic event, Item Mentel and I Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Steel Industry Steelworker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Noble Spurlock Mollie Short 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21222Mrs. Mabel W. Spurlock (Wife) 1780 Stokesly Road Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from state 10/19/2012 √5 ☐ Other (Specify) Cedar Hill Cemetery Glenn Burnie, MD 4 Dopa 21. Signature of rice propose Obar 1 39 1sher Duda-Ruck Funeral Home of Dundalk, 1 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) a SEPSIS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam ettending physicien and for use es the burlal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Day been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes '8 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) \( \text{HOSPICE} \) 2 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending To the Hospitel or Attendin within 24 hours efter deeth.

To the Funerel Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier 1 🔲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

14

only one

Signature and title of certifie

TRACIE L. MORGAN

31. Date filed (Month, Day, Year)

OCT 1 9 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

32. Registrar's Signature

2012

OCTOBER

WILLIAM SPURLOCK

Registrar DHMH 17 Rev 06-2011

State

2300 DULANEY VALLEY RD.

3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month.

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2115 Aileen Marie Stielper Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 218-14-0955 **Director** 1 M 2 X F 02/11/1924 MD Usual Residence of Deceden 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at **Funeral Director** 1 Yes 2 No Slidell TA St. Tammany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r 70458 USA 46 Wyndham Court Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, of Health and Mental Hygiene.
item 27 is marked other than "natural", or iter
other traumatic event, the Medical Examiner Armed Forces? Black, White, etc þ 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 3altimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Anna Margaret Witthauer William Webster Mulcahy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard Stielper, Sr. 46 Windham Ct., Slidell, LA 70458 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Mem'l Park 10/16/2012 Baltimore, MD Schimunek Funeral Home 22. Name and Address of Facility of Funeral Pervice Li ensee 610 W. MacPhail Rd., Bel Air, MD 21014 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cancer Immediate Cause (Final 7 cmal Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a consequence of) for use as the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗀 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 After this certificate has funeral director, page 2 2 No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{\subset}\) Nursing Home \(5 \subseteq\) Residence \(6 \subseteq\) Other (Specify) 2 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Medical Certificate: Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred iniury 5 Pending 1 Natural Accident Investigation within 24 hours after death To the Funeral Director: filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely

the

State Registrar (Check

only one)

29b. Signature and title

of certifie

Registra

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hesaneake. Dr. Bel Air. Ud.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

10

12

29c. License number H = 37

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 19:11 P M LILLIAN MARIE STEVENS Medical OCTOBER 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 126-26-3903 (Month, Day, Year) 81 **Director** 1 - M 2 F 8/26/1931 NY 28a-f shov 10c. City, Town or Location 10d. Inside City Limits Director MD HARFORD 1 🗆 Yes 2 🔀 No BEL AIR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 109 RED PUMP RD 21014 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married Completed by 2 🔀 No 1 Yes 2 No Specify. WHITE 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 4<sup>College (1-4 or 5+)</sup> Elementary/Secondary (0-12) TEACHER EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental CLYDE DECKER MARY SHEMBECK 19a. Informant's Name/Relationship (Type, Prin SUSAN WRIGHT-DAUGHTER illing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RED PUMP RD BEL AIR, MD 21014 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State ATLANTIC CREMATORY 10/17/12 GLEN BURNIE, MD 4 ☐ Donation 5 ☐ Other (Specify) . Sign ...u of Funeral Service Licens 22. Name and Address of Facility SCHIMUNEK FUNERAL ROME OF BELIATR 610 W. MACPHAIL RD BEL AIR, MD 21014 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, refeart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Cardiogenic disease or condition Medical resulting in death) Due to (or as a consequate of Examiner vocardial Sequentially list conditions, if any leading to improve cause. Enter Underlying Cause (Disease or injury that initiated events Complete heart Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Septic shock IF FEMALE: 23b. Was decedent pregnant ves, outcome of s, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, To Be Completed 1 Yes 2 No 3 Probably 4 Unknown hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No stevens Willian diabetes mellitus 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 🗷 Natural 5 Pending injury Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10/14/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WV 500 Upper Chescopack Dr. Belair, MD 21014 MP 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

EHILIOCOSM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month  $A^{\mathsf{M}}$ Edna C. Schaem 2012 8:00 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Esters Place Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Year) 07/07/1928 6 Sex Funeral 7. Age (In yrs, last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Director 1 □ M 2 🖔 F 089-20-7020 New York Yrs sual Residence of Deced item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at Director 10a, State 10h Count 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No MD **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2802 Pinewood Avenue 21214 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes. Give 1 ☐ Yes 2 ☑ No Specify: Specify Completed 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Education Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ James Collins Catherine Reddington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Mazzoleni / Daughter 684 Parsons Drive, Hood River, OR 97031 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/19/2012 Chesapeake Crematory Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility orota Marshalk Maryland Cremation Services, PO Box 1413 Baltimore. MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and attending physiclan and for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Year Day signed by the at Id be detached for Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Autonomy within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag performed? Yes 2 No 2 19 No 1 Yes Be 25. Was case referred to me 26. Place of Death (Check only one) examiner? Hospital 2 4 NO Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred **Natural** 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation М 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Megrical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Cattifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 [ 29b Signature and titl 29d. Date signed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For		State of	f Marylan				and Men	tal Hyg	giene	201	2	33692
		State Registrar				Cer	tificate of	Death			Reg. No.	201	۷ ،	33032
Physici Medi		1. Decedent's Name	Samu		ein					Pate of Dea Month OCTOB		2012		me of Death
Exami		4a. Facility Name (if		ve street and numi	ber)		4b. City, Town,	or Location of	of Death		4c. 0	County of Dea	th	
and the second	P	MILFORD  5. Social Security No.		Sex	7. Age (In yrs. la	st hirthday)	PIKES If Under 1 Year		24 Hrs. 10 D	ate of Birtl		BALTIMO		
Funeral Director		216-09-0		1 X M 2 □ F		V	Months Day			Month, Day			ountry)	tate or Foreign
		Usual Residence of	of Decedent			99 Yrs.			0	)1/17/	/1913	S M	D	
yland -f sho	cto	10a. State	10b. County		10c. City	, Town or Loc	ation							de City Limits
e Mau r 28e notifi	Director	MD 10e. Street and Nun	BALTI	MORE	PI	KESVII	~							Yes 2 No
ith th				D MTII D	10 A D		10f. Zíp Code					en of What C	ountry?	
ems:	Funeral	11. Marital Status	D MILLOR		dent Ever in U.S		2120 as Decedent of	Hispanic Orig			US.	A 4. Race - Am	erican India	an.
fer d	至	1 Never Marri	ed 2 Married		2 No		Yes, specify Cu			, etc.)		Black, Whi	te, etc.	,
Urs at	ted	3 🛛 Widowed		If Yes, Give Year or Dat	tes.	'	☐ Yes 2 🗓 N	to Specify:			S	pecify: WH	ITE	
15- 72 ho	Completed		15. Decedent's cify only highest of		9	(Give k	ent's Usual Occi	e during most	t of working	1	16b. Kin	d of Business	/Industry	
Vitnin iene.	ខ្ល	Elementary/Second 12	ondary (0-12)	College (1-	4 or 5+)	ine. DC	NOT use retire SALES	*				CLOT	HING	:
filed v all Hyg	Be	17. Father's Name (I	First, Middle, Last,	)		-		18. Moth	er's Name (Firs	t, Middle, i	Maiden St			
Variation of the state of the s	은	BARRY				STEIN		KAT	IE			UNI	KNOWN	
Maryland 2 should e filed th and Mental H 77 is mar ed of treumati		19a. Informant's Na				19b. Mailin	g Address (Stree	et and Numbe	er or Rural Rou	te Number	r, City or To	own, State, Z	ip Code)	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23a or 28e-f show whylvy or other treumatill event, the Medical Eventiner must be notified at once.		JOYCE GO: 20a. Method of Disp		LMAN/DAU			WELLSPR	ING CI		DWING				
nt of int of it		1 X Burial 2 i	Cremation 3	Removal from	State C6	emetery, crem	ition (Name of atory or other pi		Date			ation - City o		
Itin It. Pa artme ortani Injury		4 ☐ Donation 21. Signature of Fur	5 Other (Spec		BETH	I EL ME	MORIAL Name and Add	PARK 1	10/18/20	O12		NDALLS		
Bal permi Depar Impol eny Ir		21. Olginature of tall	leral Ce Lice	7			8900 RE							
		23a. Part 1. Enter ti	he disease, or cor	mplications that ca	aused the death	. Do not enter	the mode of dy	ing, such as	cardiac or resp	piratory arr	est,			ximate
Physician	a 55	Immediate Cause (I disease or conditio	Final	one cause on each	rosciero.	hr Cac	dinas	rular	- Dis	or se				al Between and Death
Medical		resulting in death)	•	a	or as a consequ		0110	( ) - (	10:	, - (				
Examiner	1	Sequentially list cor	nditions,	b. ———										
De isi	Ē	if any, leading to im cause. Line Under Cause (Disease or i	tying 1	Due to (c	or as a conseque	ence of):								
executed an and rial-transi	Exa	that initiated events resulting in death) I	3	c. Due to (c	or as a conseque	ence of):								
	dical Examiner		•	<b>=</b> d										
68760 certificate be nding physici use as the bu		IF FEMALE:	r	_ u										
Box 687 death certifica he attending p	an/l	23b. Was decedent in the past 12 r		23c. If yes, outo	ome of pregnar Birth 2  Fetal	ncy death 3 🗌	Ectopic pregna	incy			23	3d. Date of de	elivery	- }
<b>Bo</b> e deat the at hed fo	Physician/Me	1 Yes 2 9 Unknown	No	4 🔲 Pregn 9 🗋 Unkno	ant at time of do	eath 5	Other (specify)					Month	Day	Year
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as:		Part II. Other signifi	icant conditions	contributing to de	ath but not resu	ılting in the ur	derlying cause	given in Part	l. 2	23e. Did to	bacco use	e contribute to	n the cause	e of death?
S, F.	d b													4 D Unknown
Division of Vital Records, ral or Attending Physician: The law requires s after death.  In Director, After this certificate has been signed in by the funeral director, page 2 should be and in the funeral director, page 2 should be a should by the funeral director.	Completed by									24a. Was a	an I	24b. Were au	utopsy find	ings available
<b>ec</b> he lav te has age 2	E O										rmed2	prior to death?	completion	n of cause of
al Filan: T	Be C	25. Was case referre examiner?	ed to medical				26.	Place of Deat	th (Check only		2 🗖 No	1	s 2 □ N	0
Vit hysici	10	examiner? 1 ☐ Yes 2 €	TNo	Hospital:	npatient 2 🗆 I	R/Outpatient	3 □ DOA O	ther: 4 🗹 Nu	ursing Home 5	5 🗆 Resid	lence 6	Other (Spec	cify)	
n of ing P	ate:	27. Manner of Death 1 Natural	o 5 ☐ Pending	28a. Date of (Month	of injury n, Day, Year)	28b. Time of injury		vrk?		Describe h	ow injury o	occurred		
ttend death stor. /	Certificate:	2 Accident 3 Suicide	Investigation 6 Could not	he	district Attack			Yes 2						
lor A after Direct Jun by		4 Homicide	determined		of Injury - At hor g, etc. <i>(Specify)</i>		et, ractory, omce	9		ocation (Si City or Town		Number or Ru	ıral Houte I	Number,
spita bours neral y filler	Medical	29a. Certifier 1	Certifying Ph	ysician: To the be	st of my knowle	edge, death o	ccurred at the til	me, date and	place, and due	e to the ca	iuse(s) and	I manner as s	tated.	
he Ho in 24 he Fu ipletel	Med	only one 3		miner: On the basis rrse Practitioner	s of examination To the best of m	and/or investi	gation, in my opi	nion, death oc	ccurred at the tir	me, date ar	nd place, a	and due to the	cause(s) ar	nd manner stated.
o with		29b. Signature and t	title of certifier	apahru	eno		29c. Licer	ise number	,65	- [:		signed (Mont		
							150		+65			0/17		
20		30. Name and addre	ess of person who	completed cause	e of death (Item	23a) (Type, Pr	int)	203	Bal	tim	OH	MD	212	09
Sta				Cit	01	11 17 / 17	•	-			_			- /
	ite	31. Date filed (Month		_22. Re	gistrar's Signatu	ıre								
Registr			n, Day, Year) 192012	32. Re		are Java								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend 23a.c.per me, e932 10-24-12 sm
State of Maryland 7 Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER Physician/ 09:45PM RENEE SOUDRY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death LEVINDALE HEBREW HOME BALTIMORE Social Security Number 6. Sex 1 ☐ M 2 🔀 F 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign MOROCCO Months Min Hours (Month, Day, Year) 25 Director 212-33-4249 87 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7905 TERRAPIN COURT 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of
any injury or other traumatic eve JACOB TOLEDANO JAMILA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOCELYNE SILVER/DAUGHTER 7905 TERRAPIN COURT, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HAR SINAI CONG. 10/18/2012 OWINGS MILLS, MD 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Euneral Service Licensee INC. MD 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, Approximate Interval Between Onset and Death Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ a CARDIOPULMONARY disease or condition Medical resulting in death) Due to (or as a consequence of Examiner FRACTURE EFT INTERTROCHANTERIC Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) sician and burial-transit OSTEOPOROSIS Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown detached for Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5  $\square$  Pending Natural 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FALL 1 Tes 2 No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 2434 W. BEWELDE NEBAL 211215 HOME NURSING Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M D0062895 OCTOBER, 16, 2012 LEVINDALE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PANLINE DALEY BALTIMOLE Belveder AVE hest 31. Date filed (Month, Day, Year) State OCT 1 9 2012 Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 6:22 PM Physician/ Day YNTHIA THOMPSON Medical a, Facility Name (if not institution, give street and number)
MEDSTAR MONTO OME
MEDICAL CENTER 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY DLNEY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 220-58-7318 60 1 🗆 M 2 🔀 F **Director** New Jersey Aug 8, 1952 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Rockville MD Montgomery 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral items 23a USA 20853 14650 Bauer Drive permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iter edical Examiner 11. Marital Status Armed Force Black, White, etc. by 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 XDivorced Completed th and Mental Hygiene.
7 is marked other than "natul traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Public Education Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Evelyn Pearl DeHaven John Wesley Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14650 Bauer Drive Rockville, MD 20853 Department of Health ar Important: If item 27 is any injury or other trauonce. Erika Roliz/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Final Journey Crematory 10/17/12 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ SFPSIS disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** PNEUMONIA Sequentially list conditions Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of) as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Day Year Pregnant at time of death 5 Other (specify) ed by the a 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? METASTASES 24a. Was an autopsy performed? Yes 2 No page 2 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 Yes 2 No 1 Npatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at w<u>ork?</u> Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The discrete of the pasts of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

DHMH 17 Rev 06-2011

Registrar

29b. Signature and title of certifier

PRINCE

OCT 1 9 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHACHI LOVERAY

DRIVE

HILIP

29c. License number

OLNEY

D73699

10/12/2012

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Loretta J. Tumminello 2012 10:10 PM October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson 8. Date of Birth (Month, Day, Year) August 02,1935 **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Days Hours Min. 77 219-32-4309 1 □ M 24XF **Director** Baltimore, Maryland Usual Residence of Decedent or 28e-f shov 10b. County 10a. State rei", or items 23e or 28e-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Tes 2XXNo Baltimore Maryland Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 9719 Red Clover Court 21234 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. <u>ک</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "naturei" 3 KWidowed 4 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mentel Hygiene. marked other then Elementary/Secondary (0-12) College (1-4 or 5+) Manager Metro Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil.
Department of Health end Mentel
important: if item 27 is marked of
any injury or other traumatic eve မ Robert Angel Jennie Moul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Downey (Daughter) 9719 Red Clover Court Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State October 2012 Evans Funeral Chapel-Bel Forest Hill, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services—Parkville
8800 Harford Road Parkville, Maryland 21234 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat dailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami After this certificate has been signed by the attending physician and signeral director, page 2 should be detached for use es the burial-tran Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{QI} \) Other (Specify) \( \text{No.} > \( \text{P( \text{V})} \) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending in 24 hours after death.

The Funerel Director: Af pletely filled in by the fun death. 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital or Medical within 24 hound to the second 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28303 ess of person who completed cause of death (Item 23a) (Type\_Print) Charles ST TONSON MM 6701 WO 31. Date filed (Month, Day, Year) State OCT 19

DHMH 17 Rev 06-2011

Registrar

			ype or Print in Bi				-	-
		1 _ State	State of Maryland		it of Health and r e <i>of Death</i>		201	2 33696
		Registrar  1. Decedent's Name (First, Middle, Last)		Certificati	e or Dearri	Reg. 2. Date of Death	No. <u>2</u> U 1	
Physic Med	lical	Clifton	١		nev	1	Day 14 Year	3. Time of Death 2 6:00 A M
Exam	iner	4a. Facility Name (if not institution, give stre	^ ·	1 . 1	Town, or Location of Death	I	4c. County of Dea	
Funera	1	5. Social Security Number 6. Sex	7. Age (In yrs. last		ARWOOD 1 Year   If Under 24 Hrs.	8. Date of Birth		rthplace (State or Foreign
Directo		217-24-0826	M2 DF Q	Months Yrs.	Days Hours Min.	(Month, Day, Yea	ar) C	ountry)
D W	٦.	Usual Residence of Decedent  10a. State 10b. County	1000	τ		14-24-	28 M	AKYLAND
ırylan s-f sh jed a	Director	Tod. State	Tuc. City, I	Town or Location	- 0 1			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
or 28e		10e. Street and Number	INDEL	SEVE 10f. Zir		100	Citizen of What C	
with til 23a o	eral	241 ShEILA-K C	OLD T		21144	Tog.	ر کے ر	
eath v	Funeral	27.3.3.3.	2. Was Decedent Ever in U.S.	13. Was Deced	lent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Am	erican Indian,
36 iter d	þ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	1 \( \text{Yes} \)	cify Cuban, Mexican, Puerto 2 No Specify:	rican, etc.)	Black, Whi	te, etc.
15-0036 72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ferbeal Examiner must be notified at	eted	3 Widowed 4 Divorced	Year or Dates.				Specify: 6	hile
21215-0036 within 72 hours after glene. eer than "natural", o ; the Modest Exam.	Completed	(Specify only highest grade	completed)	16a. Decedent's Usu (Give kind of wo life. DO NOT use	rk done during most of worl	ring 16t	o. Kind of Business	s/industry
within glene.		Elementary/Secondary (0-12)	College (1-4 or 5+)	MEG	TACKER	I P	acking	COMPANY
al Hyded doth	Be	17. Father's Name (First, Middle, Last)		· ·	18. Mother's Nam	ne (First, Middle, Maid	len Surname)	
yla Ild be Ment narke	2		URNER		EVELYN	M. En	JOERS	5
re, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland if Heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Markeal Examiner must be notifiled at		19a. Informant's Name/Relationship (Type,	` <b>.</b> '	•	s (Street and Number or Rui			' '
and and a Healt tem 2		20a. Method of Disposition	DAUGHTER	8223 Angle ce of Disposition (Nai	SESEDGE CT.	SIEN BURI	Location - City of	Z (060)
0 0 = =		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State cem	netery, crematory or o	other place)		•	
Baltimo permit, Page Department Important: I any injury o	ē lē	21. Signature of Juneral Service Licenses	W. HR	22. Name ar	MATCAY 10 -1	16-12 OT	ENION	al House
a Ted		MINI DE	M00942		MOUNTAIN RD.			
		23a. Part 1. Enter the disease, or complic shock, or heart failure. Lies only one	ations that caused the death.					Approximate Interval Between
Physician	v (=)	Immediate Cause (Final disease or condition	C	OP.	D			Onset and Death
<ul> <li>Medica</li> <li>Examine</li> </ul>		resulting in death) a.	Due to (or as a consequer	nce of):			-	1
=Xa.IIIII	ē	Sequentially list conditions, b.		obac	co u	se		decades
ed nsit	Examin	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequer	nce of):				
be executed sician and burial-transit		that initiated events c. resulting in death) Last	Due to (or as a consequer	nce of):				
be e	ical	L <sub>d</sub>						
Box 6876C death certificate he attending phys ted for use as the	Med	IF FEMALE:						1
X 60 h cert tendir	an/I	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnance 1 🔲 Live Birth 2 🔲 Fetal c		pregnancy		23d. Date of d	1
ital Records, P.O. Box 68760 idian: The law requires that the death certificate by certificate has been signed by the attending phys rector, page 2 should be detached for use as the	Physician/Medic	1  Yes 2 No	4 ☐ Pregnant at time of dea g ☐ Unknown	ath 5 Other (s	pecify)		Month	Day Year
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  is Director: After this certificate has been signed by ed in by the funeral director, page 2 should be detac		Part II. Other significant conditions conti	ributing to death but not result	ting in the underlying	cause given in Part I.	23e. Did tobaco	co use contribute	to the cause of death?
S, F	d by	CHF						Probably 4 🗆 Unknown
ord requ	Completed	Atrial	F, L~, 11 0	1-		24a. Was an		utopsy findings available
Rechaste has age 2	E		1,-1,1,0			autopsy performed 1 2 Yes 2 2	prior to	es 2 No
al Flan: T lan: T rtifica	BeC	25. Was case referred to medical examiner?			26. Place of Death (Chec		NO ILLY	es 2 🗆 No
Vit hysic nis ce il direc	2	1 Yes 2 No	spital: 1	R/Outpatient 3 🗆 D	OA Other: 4 Nursing H	ome 5 Residence	e 6 🔀 Other (Spe	ecify) MICC
n of ing P	ate:	27. Manner of Death  1 Anatural 5 Pending	28a. Date of injury (Month, Day, Year)	injury	28c. Injury at work?	28d. Describe how in	njury occurred	Hospice
sior ttend death death stor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hom	M form street factor	1 Yes 2 No	005 1 1' (0)		10000
ior A after Direct din b	Ş	4 Homicide determined	building, etc. (Specify)	e, iaiiii, siieet, iactoi	y, office	28f. Location (Street City or Town, St		urai Houte Number,
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying Physici	ian: To the best of my knowled	dge, death occurred a	t the time, date and place,	and due to the cause(	s) and manner as	stated.
the Ho nin 24 the Fu	Med	Enty one) 3 Certifying Nurse I	r: On the basis of examination a Practitionar To the best of my	and/or investigation, in Imambedge, death so	my opinion, death occurred a surred at the time, date and p	at the time, date and place, and due to the co	lace, and due to the eurse(s) and mainer	e cause(s) and manner stated.
N T T T T T T T T T T T T T T T T T T T		29b. Signature and title of certifier	,	29	c. License number	. \	Date signed (Mor	ith, Day, Year)
		Zva	Hersh	MY	3658	, ,	10	15/12
5		30. Name and address of person who com		3a) (Type, Print)	Hospice	Fense	Hick	reserve
S	tate	31. Date filed (Month, Day Year)	32. Registry's Signar	ento		,	. I. VAII	MD 214
Regis	trar	ULI I B ZUIZ /CE	which he was					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33697 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month  $A^{M}$ Elizabeth Jane Taylor 10 2012 3:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1902 Cypress Drive Harford 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 06/15/1934 Days Director 1 □ M 2 🖒 F 214-30-5800 78 Maryland Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If the AZ is marked other then "nature" any injury or other treumetic event. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1902 Cypress Drive 21015 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Completed 3 TwWidowed 4 Divorced Specify Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Chester Jakubiak Helen Gos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Stilling / Daughter 1902 Cypress Drive, Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/18/2012 Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) UNG Medical Due to (or as) iviedicai ر Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Tes 2 No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the 3 Certifying Nurse Practition r. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ca

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who completed caus

NNQ

31. Date filed (Month, Day, Year)

of death (Item 23a) (Type, Print)

Hone

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Eme Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of De General Age (In yrs. last birthday) 1 Year If Under 24 Hrs. **Funeral** Date of Birth 9. Birthplace (State or Foreign Country) 1 □ M 2 🗹 Months Min. Director lan Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubap, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No White, etc. ģ 1 Newer Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No 3 ₩Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DQ NOT use retired) Hote Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) ပ rymstrong 19a. Informant's Name/Relationship (Ty)se 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Smith 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Desurial 2 Cremation 3 Removal from State Marylan 4 Donation 5 Other (Specify) 10in Cemeter Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequênce of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Day ☐ Yes ∠ u been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an tor: After this certificate has the funeral director, page 2: autopsy 2 No 2 1 N 1 Yes ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2012 Physician/ 5:50 AM October 0 Mae Watkins Annie Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Prince George's Lanham Magnolia Gardens 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Yes Oct. 10, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🗶 F Florida 1926 Director 262-32-1890 Usual Residence of Decedent 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No Prince George's Hyattsville 10g. Citizen of What Country? 10f. Zip Code 23a Funeral 20785 7715 Burnside Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Page 1 and 2 should be filed within 72 hours after death 11 Marital Status Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 Specify: Black 1 Yes 2X No Specify: 3 😾 Widowed 4 🗆 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) il Hygiene. other than " College (1-4 or 5+) Government Elementary/Seconday (0-12) traumatic event, the Custodian 8th Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental ! မ Mary Brown Doc Choice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) t of Health ar 7715 Burnside Road Hyattsville, MD 20785 Important: If item 27 any injury or other tr once. Dorothy May/Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Harmony Mem. Cemetery 10-19-2012 Hyattsville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. Signature of Funeral Service Licensee 7474 Landover Road, Hyattsville, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Failure to Thrive disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo Month Day Other (specify) Pregnant at time of death 1 Yes 2 L g Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical 4 X Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 27. Manner of Death Certificate: 1 X Natural 5 Pending 1 Yes 2 No Investigation Accident completed filled in by the 28f. Location (Street and Number or Rural Route Number, 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiners On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioners To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 hours Medical 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who dompleted cause of death (liter 23a) (Type, Print) Lanham, MD 20706 8200 Goodluck Road Sonja Wyche 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Rashem Fontair		/ilson State	of Maryland /	Depa	rtment o	f Heal	lth an		•		gible	20	2 3371
		Registrar_		Cen	tificate o	T Deat	n				eg. No.	20	
Physicia Medical Exami		1. Decedent's Name (First, Middle,Las Rashem Fontain	e Wilson						d	Date of Dea Month October 1	Day 5, 201		3. Time of Death 1928 hrs
		4a. Facility Name (if not institution, giv Prince George's Hospital (				4b. City, Chev		Location of	of Death			County of Dea ince Georg	
Funeral Director		5. Social Security Number 6. Sec 577-08-4132 1X	7. Age ( M 2 F		st birthday) 29 Yrs	Month	er 1 Yea ns Day		Min	Date of Bir Aay 25	•	Fore	irthplace (State or ig Washington ountry) D.C.
any.		Usual Residence of Decedent 10a. State 10b. County	10	C. City,	Town or Loca	tion							10d. Inside City Limits
Maryland 28a-f show	ctor	MD Prince	George's	Land	lover	10f. Zip	Code			<del>- 1</del> 1	Da. Citize	en of What Co	1 X Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	I Director	2104 Connecticut				207	85				USA	1	
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 X Never Married 2 Married	1 Yes 2 X		lf \	es, specif	fy Cubar	n, Mexican,	gin? ( Specif , Puerto Ric			White, etc.	rican Indian, Black,
s afte	2	3 Widowed 4 Divorced  15. Decedent's Education (Specify or	If Yes, Give Year or Dates;	-4				specify:	المامة المامة	4		Specify: B1	
36 in 72 hour han "natt	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			ost of wor	rking life	. DO NOT	use retired)	done			rindustry
With I with the r	E	8th 17. Father's Name (First, Middle, Last)			Consi	truct		Work	er 's Name (Fir	st Middle A		ivate	
e file	Bec	Russell Grant							th Wil		Maidell 0	arriamo,	
21.2 buld b I Men in marl		19a. Informant's Name/Relationship (T	ype, Print )		19b. Mailin	g Address	(Stree				nber, City	or Town, Stat	e, Zip Code)
MD 12 shoth and 12 shoth and 127 is		Faith Grant/Moth	er						Avenu	ıe, La	andov	er, MD	20785
re, land Heal		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removed from State		lace of Dispos rematory or ot			metery,	Da	ate	20c. Lo	ocation - City o	r Town, State
MO Paget onent o		4 Donation 5 Other Specify.			nony Me			tery	10-24	4-2012	Нуа	attsvil	le, Marylan
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important; If item 27 is marked other than injury or other traumante event, the Medical	Ī	21 Signature of Funeral Service Licen			22. 1	Name and	Address	of Facility	J.B.	Jenki	ins I	uneral	Home, Inc.
	_		ernelius	<u>)                                    </u>									D 20785
Physician Madical Examiner		Part I. Enter the disease, or comp failure. List only one cause on ear Immediate Cause (Final disease or condition resulting in death)		Dis	sease	ne mode (	or dynig,	Such as Ca	ardiac or res	priatory arre	est, shoc	k, or near	Approximate Interval Between Onset and Death
ed nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ										
be executed cian and urial - transit	흥	M. UNPENDED	AMENDED23a,2	7,pe	er me,g	3935	1-14	i-13 s	sm				
Division of Vital Records, P.O. Box 68760, ral or Attending Physician: The law requires that the death certificate be ra flor death.  3 Director: After this certificate has been signed by the attending physicited in by the funeral director, page 2 should be detached for use as the built.		IF FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at tim		2 Fe	tal death	3 [ cify)	Ectopic	pregnancy			Date of deliver fonth	y Day Year
that the detached	by Ph	Part II. Other significant conditions	contributing to death be	ut not res	sulting in the u	underlying	cause g	iven in Par	rt I.				the cause of death?
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atternompletely filled in by the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director of	Completed									24a. Was a autop:	an sy	24b. Were a	utopsy findings available completion of cause of
Rec The ficate	녨									1 ✓ Yes 2		1 🗸 Y	es 2 No
ician:	Be	25. Was case referred to medical examiner?	ospital:		-DIO 1 17 1			Other	Check only				
Phys Phys er this	라	1 Yes 2 No 27. Manner of Death	28a. Date of Injury		R/Outpatient 28b. Time of I			y at Work?	Nursing Ho	Describe h	Residend		DF:
ion c ttending death. ttor: Aft	ation	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)			.,,,		es 2	l l	. Doddribo .	iow injury	Cosamou	
Division of Vital Rector to the Hospital or Attending Physician: The Within 24 hours after death.  To the Funeral Director: After this certificate completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined		- At hon	ne, farm, stre	et, factory,	office b	uilding, etc	28f.	Location (S or Town, St		Number or R	ural Route Number, City
To the Hospita within 24 hours To the Runeral completely fille	ल		an: To the best of my kr On the basis of examin and manner stated.										
HSES	Me	29b. Signature and title of certifier	James Galley,			29c	. License	e number			29d. Da	ate signed (Mo	onth, Day, Year)
	-	30 Name and address of person who c	ompleted carse of deal	N/ltem 2	) (23a)		O.C.N	И.E.			Octob	per 16, 201	2
0			Assistant Medical			W. Balt	imore	Street, E	Baltimore	, MD 212	223		
Sta Regist	~~	31. Date filed (Month, Day, Year)	2. Registrar's	Signature	but	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Peath Month Physician/ OSE 3451 09 Medical 4a. Facility Name (if not institution, give street and number) Baltimus **Examiner** 4c. County of Death ockeoin 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days (Month, Day, Year) 34-034 Director 1 🗆 M 2 🔽 10/06/1936 Maryland 27 is marked other then "natural", or items 23e or 28e-f show treumetic event, it e Medical Examinant to motified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 √Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2434 W. Belvedere Avenue 21215 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: black 3 X Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Ò medical billing healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental H 7 is marked o ၉ Henry James Brown Annie Lee Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: if item 27 is eny injury or other trea once. Rhonda Richardson/daughter 2500 N. Longwood Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 
☐ Donation 5 ☐ Other (Specify) Kare and Address of Facility
Board 655 W. Baltimore Street 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner (oc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a possequence of): Examin the attending physicien and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physicien: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Year 1 Yes 2 Unknown cate has been signed by the a page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funerel director, pag 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check re and title of certifier 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year)

OCT 1 9 2012 32. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a per FH G932 10/26/2012 IIII and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ РМ Medical 10 2012 2:10 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Har Lerch Aberdeen 4.16 713 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days (Month, Day, Year) Hours Director 1 □ M 2 F 227-22-4941 06/21/1928 Kentucky 84 Yrs Usual Residence of Decede J. Hygiane. othar than "natural", or itams 23a or 28a-f show vant, the Medical Expansion must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director tX☐ Yes 2 ☐ No MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 713 Gilbert Road 21001 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Completed 3 ₩ Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filled wit Department of Health and Mental Hygian important: If item 27 is marked other 1 any injury or other traumatic avent, III. 2006. Hospitality Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Farmer Hoskins Emma Winifred Baker 19a. Informant's Name/Relationship (Type, Print) **Brand** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexis L. Wright / Daughter 713 Gilbert Road, Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/19/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysiciani disease or condition resulting in death) drahun Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir attending physician and I for use as tha burial-transit or Attanding Physician: Tha law requires that tha death certificate be executed Cause (Disease or injury that initiated events CU14 Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? ate has been signad by the a pege 2 should be detached t 1 ☐ Yes 2 🔀 No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ASCUD 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an COY O To the Hospital or Attanding Physician: Tha law within 24 hours aftar death.

To tha Funarai Director: After this certificate has complately filled in by the funaral director, pege 2 performed' End Ske 2 🗌 No 1 ☐ Yes 2 🗷 No 1 🗌 Yes 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 🕱 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 🗌 Yes 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D 3/295 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltomore 5701 Kenwush 21206 MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 Registrar

DHMH 17 Rev 06-2011

2-07804 eidre Young			or Print in Bl						egible	20	2 3371
255 L		1- For State Registrar		Certi	ificate of	Death			Reg. No.		
Physicia		Decedent's Name (First, Middle,L.	ast)					Date of De     Month	Day	Year	3. Time of Death
ledical Exami	ner	Deirdre Lynn 4a. Facility Name (if not institution, or	Young		14	b. City, Town, or	Loostian of Da	October	14, 20	12 County of Dea	1818 hrs
		Prince Georges Hospital	*		41	Cheverly	Location of De	atri		rince Georg	
Funeral				e (In yrs. las	t birthday)	If Under 1 Yea	r If Under 24h	Irs. 8. Date of B		` `	irthplace (State or
Director			M 2XF		48 Yrs.	Months Day		Feb.		1964 Fore	ountry) D.C.
Á		Usual Residence of Decedent  10a, State 10b, County		10c City T	own or Locatio	.n					10d. Inside City Limits
ow any			Cassasia								1 Yes 2 No
th the Maryland 23a or 28a-f show	힕	MD Prince  10e. Street and Number	George's	uppe	r Marll	10f. Zip Code			10a Cit	zen of What Co	21
e Mar or 28s	Director					,			_		unit y ?
ith th		12811 Peachlea	f Court  12. Was Decedent	Ever in II S	13 14/20	20774	mania Origina /	Specify Yes or N	USA		erican Indian, Black,
ath w	Funeral	1 Never Married 2 Marrie	ed Armed Forces?			s, specify Cubar			.0-	White, etc.	rican indian, black,
ter de		3 Widowed 4 Divorce	1 Yes 2 ed If Yes, Give Year	X No	1	Yes 2 X No	specify:			Specify: Bla	alr.
nurs af	g Q	15. Decedent's Education (Specify	or Dates:	pleted) 1	6a. Decedent's	s Usual Occupat	tion (Give kind o		16b.	Kind of Business	
72 ho	ete	Elementary/Secondary (0-12)	College (1-4 or 5	5+)	during mos	st of working life	. DO NOT use r	etired)		-	
5-0036 led within 72 hours after Hygiene. other than "natural" the Medical Examines	Completed		3yrs		Secret	tary				Private	
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene. In 77 is marked other than 1 market over, the Medica		17. Father's Name (First, Middle, La	st)				18.Mother's Na	me (First, Middle,	, Maiden	Surname)	
121 d be f lental arke	8	Cornell Young 19a. Informant's Name/Relationship	(T		100 12 10	1.11		Dawson			
D 2 shoul and N 7 is m	ှင			- 1				r Rural Route Nu		-	
and 2 ealth cen 2 traum	ŀ	Irene D. Young  20a. Method of Disposition	/Motner	20b. Pla		ion (Name of cer		05 Lando Date		MD Z0 / Location - City of	
Baltimore, MD 21215-0036 semit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: Witem 77 is marked other than "natural", or items 23a or 28a-fab. njury or other traumatic event, the Medical Examiner must be notified at once		1 Burial 2 X Cremation 3	Removal from Sta		ematory or other		.			•	•
ti Pag treent	-	4 Donation 5 Other Speci	<u>,                                      </u>	Riv		Cremato	ory 10	0-18-201	2 Ri	verdale	, Maryland
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Med		21 Signature of Funeral Service Lice	onsee								Home, Inc.
Physician	$\dashv$	23a. Part I. Enter the disease, or con	nplications that caused	the death. D	o not enter the	mode of dying,	such as cardia	or respiratory a	rrest, she	ock, or heart	MD 20785 Approximate Interval
/Medical	ļ	failure. List only one cause on	<sup>each line.</sup> <sub>a.</sub> Smoke <b>inhalat</b> io								Between Onset and Death
Examiner	- 1	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse		annar mjune	es with comp	Dilications				
		Sequentially list conditions,	b								
V.	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of):							
	ai	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):							
3 7 2	_		d.								
اء <u>ت</u> د د	Physician/Medica	UNPENDED [	X AMENDED#1	as not	ed,per	me,g932	2 10-24	-12 sm			
760, ficate be exe y physician the burial -	ğ	IF FEMALE:	23c. If yes, outcon	ne of pregna	ncy				23	d. Date of delive	ry
Box 68760 e death certificate be the attending physicate of for use as the bu	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth  Pregnant at	time of doct		aldeath 3	Ectopic preg	nancy		Month	Day Year
lox 6 eath cer attendifor use	/sic	1 Yes 2 No 9 ✔ Unknow		time or deat	n 5 Othe	er (Specify)					
true d		Part II. Other significant conditions		but not res	ulting in the un	derlying cause g	given in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
i, P.O. ires that th signed by I be detach	ğ							1 🗌 Ye	es 2	No 3 Pro	obably 4 🗹 Unknown
rds, require been si	Completed							- 24a. Was	s an		autopsy findings available
COF law r has b	힑							auto perf	psy orm <u>ed</u> ?	prior to death?	completion of cause of
tal Rec	ઢા		<del></del>						2 🗸 N	o 1 🗌 Y	res 2 No
ician ician s certi	8	25. Was case referred to medical examiner?	Hospital: 1 / Inpatie	at 2 ===	R/Outpatient		of Death (Chec	sing Home 5	Deside	ence 6 Othe	
of Vi Physical ter this	의	1 ✓ Yes 2 No 27. Manner of Death	28a Date of Inju	rv I2	8b. Time of Inj		ry at Work?	28d Describe			er: 
on of ading Pl th. r: After re funera	틸	1 Natural 5 Pending	FOUND: Day,Y	ear) F	OUND:	·	res 2 ✓ No			in housefire	
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	<u>[3</u>	2 Accident Investiga	oct 14, 2012		0330 hrs ne, farm, street,	, factory, office b		28f. Location	(Street a	ind Number or R	tural Route Number, City
Div	Certification:	3 Suicide 6 Could no determin	ot be				<b>U</b> ,	or Town,	State)	Court, Upper M	
<b>평</b> 4 달 등		29a. Certifier (Check only 1 Certifying Phys.	cian: To the best of my er:On the basis of exar	y knowledge	, death occurre			nd due to the cau	use(s) ar	d manner as sta	ited.
To the within To the complet	Medical	29b. Signature and title of certifier	and manner stated.			29c. Licens		-, -,		Date signed (M	
			Kind 3	- 1		O.C.I		OME		ober 15, 201	
	- 1	- Munckey W.	Rd-d J	They a	1						

DHMH 17 Rev 1/2001

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

30. Name and address of person who completed cause of death (Item 23a)

Theodore M. King, Jr., MD.

State 31. Date filed (Month, Day, Year)
Registrar 0CT 1 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10-10-2012 HELEN YAMRUS М Medical 9:35 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS TIMONIUM BALTO. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Director 189-05-4730 1 □ M 2 X F 98 8-23-1914 PENNSYLVANIA Usual Residence of Dece ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10b. Count 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No MD. HARFORD BEL AIR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2343 PENNINGTON ROAD 21015 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗶 No If Yes, Give Black White etc. δ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 □XWidowed 4 □ Divorced p. II Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 7TH MACHINE OPERATOR SILK/TEXTILE MILLS Be permit. Page 1 end 2 should be filed. Department of Health and Mental Hyy Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ PETER YANCHICK 2012 SUSAN LIPA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS YAMRUS SON PENNINGTON ROAD BEL ATR MD 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State K Burial 2 Cremation 3 Removal from State OCTOBER ST. MARY'S CEMETERY 10-15-2012 HANOVER TOWNSHIP, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee SCHIMUNEK FUNERAL HOME, INC. 22. Name and Address of Facility かり 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DISEASE Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Unuerlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗶 No Month 5 Other (specify) Day 4 Pregnant at time of death ate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 🗶 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical Be Division of Vital 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident М Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 - Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗖 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the causals) and manner as stated To the I within 2 To the I only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) || V CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 TRACIE L. MORGAN, 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 16 2012 09:34P M **JOSEPH** DAVID YAVER Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GILCHRIST HOSPICE OF HOWARD COUNTY COLUMBIA HOWARD If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days Hours Min. (Month, Day, Year) Director 219-74-2357 1 X M 2 D F 47 01/16/1965 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 No MD HOWARD LAUREL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9399 SEWELL AVENUE 20723 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by 3altimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than 'amy injury or other traumatic event, the Meaonee. Elementary/Secondary (0-12) College (1-4 or 5+) SOFTWARE ENGINEER CONSULTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LAZEL **JAWER** MASHA GOLDRING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9399 SEWELL AVENUE, LAUREL, SYBIL YAVER/WIFE MD 20723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) COLUMBIA MEMORIAL PARK 10/18/2012 BALTIMORE, MD 21. Sig sture o Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANGIO CARCCIOMA Physician 0 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): sician and burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 No ed by the a g Unknown g Unknown within 24 hours after death,

To the Funeral Director: After this certificate has been signed I completely filled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 2 | No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Spec 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 100 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 1)25201 N. Charles St. Botto. Md 21204 and address of person who completed cause of death (Item 23a) (Type, Print) 6701 GBIN 10 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year SEPTEMBER 29 2012 **Physician** DO I DAM HAM3 TA7 ALTELAIHI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🖵 F 72 Jan. 1, 1940 Kuwait **Director** Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County show or 28a-f shov notified at 1 ☐ Yes 2 X No Director Kuwait Kuwait 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code items 23a or ò death with Al Rodah, Block 5 52th Street Kuwait Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status ral", or iter Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify: White ð 3 X Widowed 4 Divorced Year or Dates "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene.

is marked other than Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lolwa Saleh Alawais Shahab Ahmed Altelaihi 2 traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Son) Al Rodah, Block 5, 52th Street #9 Kuwait, Kuwait item 27 Fahad Jasim Alabdullah other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ott once, 1 X Burial 2 Cremation 3 Removal from State Alsulaybekhat Cemetery 10/5/12 Kuwait 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Metropolitan Funeral Service 5517 Vine Street Alexandria, VA 22310 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2 day elevation Myocardia /Medical Due to (or as a consequence of): Examiner 1ears labetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). s the burial-transit empheral Vascular Pars The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy Live birth 2 Fetal death Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 2 □ No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 2 🗆 No 25 No. 1 Tyes Be Certification: To After

Division of Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: s after death.

I Director: After in by the fu within 24 hours after
To the Funeral Directory
Completely filled in by

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No		26. Place of Death (Check only one)									
		Hospital: r⊈Inpatient 2□	ER/Outpatient	3 🗆 🛭	OA Other: 4 Nursing F	lome 5 ☐ Residence	6 ☐ Other (Specify)				
27. Manner of Deatl 1 Natural 2  Accident		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ary occurred				
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ome, farm, stree (y)	t, facto	ry, office	28f. Location (Street a City or Town, State	nd Number or Rural Route Number, e)				
29a. Certifier	1 Certifying Ph	ysician: To the best of my kno	wiedge, death o	ccurre	d at the time, date and plac	e, and due to the cause(	s) and manner as stated.				

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

RES-000

SEPTEMBER 29, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MWAKINGWE 4GNES

4940 Eastern Avenue, Baltimore, MD, 21224

State Registrar

Medical

(check only one)

31. Date filed (Month, Day, Year)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1 Year Physician/ Month 530 Al-Sanali 2012 ahani ctober Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore CHY The Johns Hopkins Huspital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth g. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Director None 1 🗆 M 2 🗶 F 1979 Kuwait 32 Nov. 15, ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location rector 1 X Yes 2 □ No Khaldiya Kuwait Kuwait ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17645 BLK 3, St 30, House #1 Kuwait Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. Specify Middle Eastern þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r life. DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) Ministry of Commerce other traumatic event, the Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dalal Al-Nasser Abdulatif Al-Sahali 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau of Health BLK 3, St. 30, House #1, Khaldiya, Kuwait, 17645 Brother Hamad Al-Sahali 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, Page 1 1 💹 Burial 2 🗆 Cremation 3 🗆 Removal from State 10/05/2012 4 Donation 5 Other (Specify) Alsulaybekhat Cemetery Kuwait 22. Name and Address of Facility Metropolitan Funeral Service, INC 21. Signature of Funeral Si rvice Lice 5517 Vine St., Alexandria, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Preumonia disease or condition / Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to increasing cause. Enter Underlying Examine Dire to (or se a consequence of, Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day 5 Other (specify) ed by the a g 🗌 Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 2 No 1 Yes 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

1 Yes 2 No page 2 has death?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has the funeral Director. completely filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 **V** No ည 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending iniury Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 Res-000 October

State Registrar 1800 Orieans street Balto

2128

mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

an

Registrar's

C

VIA

hristine

(Month, Day, Year)
OCT 0 2 2012

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Day 27 Year Month 1258 Mara 3 67 Medical 4a. Facility Name (if not institution, give street and number) Examiner Town or Location of Death 4c. County of Death Merdend Medul Mimu, MD If Under 24 Hrs. Social Security Numbe If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 141-28-9605 76 Director 1 🗆 M 2 🔀 F 6/7/1936 NEW JERSEY 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director HEDGESVILLE BERKELEY W۷ 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 25427 178 ARROWHEAD RIDGE USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify WHITE 3 X Widowed 4 Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

ADMINISTRATIVE ASST. and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) C.I.A. event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ULRICH SCHNARR 2 Department of Health and Ment. VIOLA SIEGEL 19a. Informant's Name/Relationship (Type, Print)
SHARON BOSTON/DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 4330 NEWPORT AVENUE, BALTIMORE, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State SMITHSBURG, MD SMITHSBURG CREMATORY 4 Donation 5 Other (Specify) Signature of Funeral Service Licenece 22. Name and Address of Facility BROWN FUNERAL HOME PO BOX 821, 40 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed attending physician for use as the buria Physician/Medical Box 68760 yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 9 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year signed by the a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, No 3 Probably 4 Unknown 1 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performaty? has page 2 After this certificate No. 1 Yes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ည 🍂 Inpatient 2 🗆 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury n 24 hours after death. he Funeral Director; A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier < 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifie NYI 29c. License number 29d. Date signed (Month, Day, Year, 2

Registrar

State

31. Date filed (Mg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Wise,

nth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 33709

		# FOF	ertificate of Death		2012 33709
Physici	ian/	Decedent's Name (First, Middle, Last)	. 1	2. Date of Death Month <b>October</b>	Day Year 3. Time of Death 1311 M
Med Exami		Warren Stewart Ba:  4a. Facility Name (if not institution, give street and number)	Lley 4b. City, Town, or Location of Death	OCTOBEL	4c. County of Death
		46070 Warrick Drive	Lexington Park		St. Mary's
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	
*		Usual Residence of Decedent 62		11/22/1	
yland -f sho	ctor	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
ne Mar or 28a notifi	Director	Maryland St. Mary's Lexin	ngton Park  10f. Zip Code	100	. Citizen of What Country?
with the s 23a c	Funeral	46070 Warrick Drive	20653		USA
death • items		11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
land 21215-0036  be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "ratural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	d by	1 Never Married 2 Married 1 X Yes 2 No If Yes, Give Year or Dates,	1 ☐ Yes 2 X No Specify:		Specify: White
5-00	Completed	15. Decedent's Education 16a. Dec	edent's Usual Occupation e kind of work done during most of worki	ing 16	6b. Kind of Business/Industry
121 thin 72 ane. than he Me	Som	Elementary/Secondary (0-12) College (1-4 or 5+)	DO NOT use retired) lorse Trainer		Horses
led will Hygie other ent, t	Be	11 17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	iden Surname)
Maryland should be file n and Mental I 7 is marked or raumatic eve	은	Robert Foster Bailey, Sr.	Lena	Catherin	e Edwards
re, Maryland 21215-0036 1 and 2 should be filed within 72 hours after if Health and Mental Hygiene. item 27 is marked other than "natural", o other traumatic event, the Medical Exam			ling Address (Street and Number or Rura		
e, M and 2 s Health tem 27		20a Method of Disposition 20b Place of Disp	O Warrick Dr., Lex		Dc. Location - City or Town, State
Baltimore,  permit. Page 1 and Department of Hea Important: If item any injury or other		1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ematory or other place) y-Gardiner ome,PA Crematory 10/(	08/2012	Leonardtown, MD
Baltimore, In permit. Page 1 and 2 Department of Health Important. If item 2 any injury or other 1 page.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility  Mattingley—Gardin  41590 Fenwick st.	ner Funer	al Home, P.A.
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest	Approximate
Physician		Immediate Cause (Final disease or condition	(ancer of the	e Lung	Interval Between Onset and Death
Medica Examine	-	resulting in death)  Due to (or as a consequence of):	0	/	
n to	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
760 cate be executed physician and sthe burial-transit	Exar	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):			
be ex/sician	edical	d			
		IF FEMALE:			
P.O. Box 68; that the death certificated by the attending	Physician/N	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy     Other (specify)		23d. Date of delivery  Month Day Year
he degy the ground	hysic	1   Yes 2   No 9   Unknown			
ords, P.O. Bove requires that the despensioned by the sendence should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the			cco use contribute to the cause of death?
ds,	ted	Atheroslewsis, Coronn	7 MRIENCES		2 No 3 Probably 4 Unknown
e law re has b	Completed by	DiAbeter Welliters. Type	d	24a. Was an autopsy performe	
I R in: The ificate or, pag		25. Was case referred to medical	26. Place of Death (Chec	1 Yes 2 k only one)	No 1 Yes 2 No
Vita nysicia nis cert I direct	To Be	examiner? 1   Yes 2   No	ient 3 DOA Other: 4 Nursing Ho	ome 5 Residen	ce 6 Other (Specify)
Division of Vital Records, tal or Attending Physician: The law requires rs after death.  In Director, After this certificate has been signed in by the funeral director, page 2 should be to be the funeral director, page 2 should be the funeral director.		27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time injury	work?	28d. Describe how	injury occurred
Sior Attend death ctor: A	Certificate:	2 Accident   Investigation   3 Suicide   6 Could not be   4 Homicide   determined   28e. Place of Injury - At home, farm, to the state of the stat			et and Number or Rural Route Number,
Oivis alor A safter safter al Direct bed in b		4 Homicide determined building, etc. (Specify)		City or Town,	State)
Division of Vital Records, P.O. Box 68 to the Hospital or Attending Physician: The law requires that the death certificate has been signed by the attending to the Funeral Director After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, deat only one) 3 Certifying Nurse Practitioner: To the best of my knowled	estigation, in my opinion, death occurred a	t the time, date and	place, and due to the cause(s) and manner stated.
To the within To the compl	Σ	29b. Signature and title of certifier	29c, License number		d. Date-signed (Month, Day, Year)
		Marley Colomo M	1 17-14-26	6	ociusar of xold
5+1 pm	e	30 Name and actiress of asson who completed cause of death (Item 23a) (Type		112, Az	10 Andis MD 21401
	tate		als		
			· · · · · · · · · · · · · · · · · · ·		

Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 30 2012 10:40 Gerald C. Brooks Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis Bay Ridge Health Care Center . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days June 25 New Jersev Hours Director 579-76-4327 55 DXM 2 F permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County Director 1 XX Yes 2 No Maryland Anne Arundel Lothian 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 125 A Main Street 20711 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 HNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 A No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th 0 Security Guard <u> Hospital</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles L. Brooks Mary Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2077419a. Informant's Name/Relationship (Type, Print) Angelica Brooks (Daughter) 12414 Open View La. Upper Marlboro, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory 10/2/12 Baltimore, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Withing a Recors cof Facility Sons Mortuary, P.A. Annapolis, Lavry 21401 1922 Forest Dr. 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one caus Immediate Cause (Final Physician disease or condition resulting in death) Medical Tue to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☑ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 8 Other: 2 1 No 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 8 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATTSUILLE State 3 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2017 3:20 P M Mildred Neale Baltz October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Williamsport Homewood at Williamsport Washington County Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Min (Month, Day, Year) 229-01-2989 Director 1 ☐ M 2 🗓 F 102 Oct. 23,1909 Virginia 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Williamsport 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16505 Virginia Ave 21795 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc 1 Yes 2 No If Yes, Give Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Reading Consultant Publishing Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Wayland Dunaway Neale Mary Virginia James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Curran-daughter 1008 Hull Court Earlham, IA 50072 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Grove Cemetery | 10-10-2012 | Bealeton, VA Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications the use of he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause (n) ach line. Immediate Cause (Final 766m Physician ease or condition Medical resulting in death) for as a consequence of Examiner Unavi Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The lew requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 9 Unknown significant conditions ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 → No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu 29d. Date signed (Month, Day, Year) accia

State Registrar (Item 23a) (Type, Print)

egistrar's Signatu

no completed cause of o

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 29, 2012 8:43 A M Laura R. Brown September Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City. Town, or Location of Death Wilson Health Care Center Montgomery Gaithersburg Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign If Under If Under 24 Hrs **Funeral** 1 □ M 2 🛚 F Country) 0370171929 Director 170-22-6078 83 Usual Residence of Decedent Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Village Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral United States 19536 Desmet Place 20886 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 X Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Himes Besse Kemper Pau1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19536 Desmet Place, Montgomery Village, MD. 20886 Important: If item 27 any injury or other to once, Kathi Rhodes/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State □ Burial 2 K Cremation 3 N Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 09/29/2012 Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home ure of Funeral Service License 20877 MD. East Deer Park Dr., Gaithersburg, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ respirator month disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** year Sequentially list conditions. If any, leading to immedia cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) the buria physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) atte for in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant Pregnant at time of death detached s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sh autopsy 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify, Hospital 2 A NO ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural injury 5 Pending 2 Accident Investigation 24 hours after death Funeral Director: pleted filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. only one the d title of certifie 29b. Signature 29d. Date signed (Month, Day, Year) 0 stember 29 2014

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

37. Registrar's Signatur

Melnick

12

02 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0234 M Ronald Howard Bounds Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center Salisbury Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 220329101 Days Min (Month, Day, Year) Director 1 🙀 M 2 🗆 F 08/05/1937 Maryland permit. Pege 1 and 2 should be filad within 72 hours efter death with tha Meryland Dapertment of Heelth and Mental Hyglene. Important: If Item 27 is merked other then "netural", or items 23e or 28e-f show any injury or other traumetic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location Director Maryland 1 Yes 2 X No Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21863 IISA 3554 Bayside Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 1 Never Married 2 Married Ŕ Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Phone Company Engineer B 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Howard Lee Bounds Alice Elizabeth Culver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3554 Bayside Rd., Snow Hill, MD 21863 Janice L. Bounds/Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery 9/30/2012 Eden, MD 21. Signature of Funeral Service Dicenses <sup>22</sup> Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NGESTIVE Physician 20010MY OPATHY ase or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) cate hes been signed by the ettanding physicien and page 2 should be datechad for use es tha buriel-trensit or Attending Physicien: The lew requires that the deeth certificate be executed Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed VOLVULUS WITH 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Aftar this certificate hes autopsy perform SAN GRENE CALITIS Yes 2 No 1 Yes 2 No 25. Was case referred to medical the funerel director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Tes 2 🛛 No 1 
Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hoepital or Attending within 24 hours effer death.
To the Funerel Director: Afte completely filled in by the fun 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certi-29c. License number MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 1CHOLAS 31. Date filed (Month, Day, Year) egistrar's Signature 2 2012 Registrar

7440 I Ann Mercl		1- For State Certificate of Death	Hygiene 2012 337
Physici		Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Death 3. Time of Death
lical Exami		CAROL ANN MERCHANT BATCHELOR	Month Day Year 1651 hrs
		4a. Facility Name (if not institution, give street and number)  22072 Harrington Park Road  4b. City, Town, or Location of Dec Rock Hall	ath 4c. County of Death Kent
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I fl Under 24	Foreign
Director		216-56-1054 1 M 2 F 49 Yrs. Months Days Hours N Usual Residence of Decedent	May 14 1963 Country) MD.
any	Ì	10a, State 10b. County 10c. City, Town or Location	10d. Inside City Limi
Maryland 28a-f show i at once.	5	MD. Kent Rock Hall	1 Yes 2 X
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiewith Important of Health and Mental Hygiewith Important: If item 27 is marked other than "matural", or items 23a or 28a-f shou injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. Zip Code 22072 Harrington Park Rd. 21661	10g. Citizen of What Country? U.S.A.
n with ms 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Pue	
or ite	اڌِ	1 Yes 2 X No	
after al",	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Specify: White
hours natur Exam	8	15. Decedent's Education (Specify only highest grade completed)  16a, Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use of the during most of working life.	
in 72 than	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  12 Parts Department Sale	es Marina
d with giene	ē		me (First, Middle, Maiden Surname)
e file Files Hy	Be C		tte Higgins
Meni Meni mark	To E		or Rural Route Number, City or Town, State, Zip Code)
12 shoth and the and 127 is	<i>'</i>	Charlotte Merchant (mother) 22080 Harrington Pa	ark Rd. Rock Hall, MD. 21661
Head I and	Ì	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State
ages ant of othe			10/3/12 Smyrna, DE.
nit. F	ŀ	4 Solvetion 5 Source Specify.	me of Stephen L. Schaech
		M00510 Galena Funeral Ho	me of Stephen L. Schaech . Galena, MD. 21635
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Hanging  Due to (or as a consequence of):  Sequentially list conditions,	c or respiratory arrest, shock, or heart Approximate Intervent Between Onset and Death
d sit	cal Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):	
executed ian and al - transi		d. UNPENDED AMENDED	
ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit		23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   1	23d. Date of delivery  Month Day Year
d by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.	23e. Did tobacco use contribute to the cause of death?
uires th	ed by		1 Yes 2 No 3 Probably 4 Unknown
To the Hospital or Attending Physician: The law requires that the dwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Completed		24a. Was an autopsy prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No
ertific	Be C	25. Was case referred to medical 26.Place of Death (Chec	ck only one)
hysici this c	0	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other 4 Nurse	sing Home 5 Residence 6 🗹 Other: Scene
	tion: T	27. Manner of Death  1 Natural 5 Pending Pounds: 28a. Date of Injury FOUND: 4 Corident Investigation Oct 1, 2012  28b. Time of Injury 28c. Injury at Work? FOUND: 1 Yes 2 V No	28d. Describe how injury occurred Subject hanged self
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined Coperity Mobile Home  1 Accident Investigation Oct 1, 2012 1615 hrs 2  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Mobile Home	28f. Location (Street and Number or Rural Route Number, City or Town, State) 22072 Harrington Park Road, Rock Hall, MD
To the Hospital within 24 hours a To the Funeral completely filled	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred	
To To	Mec	and manner stated.  29b. Signature and title of certifier  29c. License number	29d. Date signed (Month, Day, Year)
	-	Carde Hallair O.C.M.E.	October 2, 2012
A	- 1	30. Name and address of person who completed cause of death (Item 23a)	
3 W		Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimor	re, MD 21223

DHMH 17 Rev 1/2001

**ORIGINAL** 

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Thomas Alfred Burch, Jr. Physician/ October 5, 2012 ear 10:10P. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Prince George's Laurel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Min. Hours OCT.11, 1939 Maryland 215-38-6126 **Director** 1 DXM 2 □ F 72 ms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location Director Maryland Prince George's Beltsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4711 Montgomery Place 20705 United States ural", or items? 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces?
1 ☐ Yes 2X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2X No Specify: White If Yes, Give "natural", 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates 1 and 2 should be filed within 72 houn of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Technical Illustrator Engineering Be 18, Mother's Name (First, Middle, Maiden Surname) Theresa Inez Linkin th and Mental H. 7 is mark Father's Name (First, Middle, Last) Thomas Alfred Burch, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health a: If item 27 is Judith Anne Burch -wife 4711 Montgomery Place Beltsville, Maryland 20705 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 10/13/2012 Brentwood, Maryland 21. Sig Little of Fuller Lervice Lice Bonald Wrssborgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 WA KON 23b. Part 1. Enter the disease, shock, or heart failure. Lin omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ Severe Anemia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Severe Coagulopathy Sequentially list conditions. Examine Divide for each consequence of trany leading to immediate. Enter Underlying Cause (Disease or injury that the death certificate be executed Septic Shock sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hypoxic Encephalopathy Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2 No 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 24 No this certificate 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔀 No မ 1 ☐ Inpatient 2 【XER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Certificate: 27. Manner of Death 1 \( \Delta \) Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aff completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier

State

Registrar

31. Date filed (Month, Day, Year)

OCT 19

DHMH 17 Rev 06-2011

Zorayda Lee-Llacer, M.D. LRH 7300 Van Dusen Road Laurel, Maryland 20707

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D12962

29d. Date signed (Month, Day, Year)

October 6, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 25, 2012 3:02P.M Sept. Samuel Ellsworth Bruce Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) 215-70-2131 **Director** 1 X M 2 D F 05/25/1968 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Charles Waldorf MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15425 Woodville Rd. 20601 United States ed other than "natural", or items are event, the Medical Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Transportation Engineer State Hwy. Admin. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental H John Franklin Bruce, Sr. Rita Mae Best Jet 1 and 2 sh. Jet 2 sh. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15425 Woodville Rd., Waldorf, MD 20601 Rita Bruce/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) METRO. CREMATORY 10/9/12 ALEXANDRIA, VIRGINIA 21. Signature of Funeral Service Licens 22. Name and Address of Facility Raymond Funeral Svc., P.A. MO1517 5635 Washington Ave., La Plata, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ESPIZATURT disease or condition resulting in death) ARDIOUNSCULAR Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) Year 4 Pregnant signed by the a ld be detached f 1 Yes 2 g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FAILURE Hospital or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No MORALD DIBESITY 24a. Was an page 2 autopsy this certificate 25. Was case referred to medical examiner? Division of Vital Be ( 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Dypatient 2 D 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending 24 hours after death. e Funeral Director: Al pletely filled in by the fu Investigation 6 Could not be 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check the only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 072199

State Registrar 31. Date filed (Month

2001 medical Parhuay Acception, and 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A14

Registrar's Signat

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Collins S Month Physician/ Year 1410 M 201 .2 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death SALVER M45 none 7000 gramo If Under 1 Year If Under 24 Hrs. 6. Date of Birth
Months Days Hours Min. (Month Day) 5. Social Security Numbe 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** Days 1 X M 2 D F Hours Min. April 82 579-36-0514 Maryland Director 1930 Usual Residence of Decedent 28a-f shov 10a. State 10h. County 10c. City, Town or Location the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No MI Silver Spring Montgomery 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1910 Marymont Road 20906 United States death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married "natural", or Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 So Specify: White 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working should be filed within 72 I and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Printing Printer 12 0 injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lydia Vivian Fletcher John Wilbert Collins, Sr. 1 and 2 should be I Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 15700 Tierra Drive, Silver Spring, MD 20906 Carolyn J. Marsal/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or otl Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Union Cemetery 10/02/12 Burtonsville, MD 4 Donation 5 Other (Specify) 21. Signature of Fundral Service 22. Name and Address of Facility Barber Funeral Home Laytonsville, Maryland 20882 P.O. Box 5038, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ASC. Immediate Cause (Final Onset and Death Physician/ ) 1776 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): inding physician use as the burial Physician/Medical Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter in the past 12 months?

1 Yes 2 No
9 Unknown for 5 Other (specify) Month Day Year Pregnant at time of death by the a 9 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 💢 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performe this certificate Division of Vital 25. Was case referred to medica director, 26. Place of Death (Check only one) Be examiner? 1 X Yes Other: 4  $\square$  Nursing Home 5  $\cancel{k}$  Residence 6  $\square$  Other (Specify) 2 🗆 No ည 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 2 Accident iniury work? 1 ☐ Yes 2 🙀 No 5 Pending Fa11 Investigation 7 2012 0900 within 24 hours after death

To the Funeral Director: 
completed filled in by the 201 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rwal Route Number, City or Town, State) 4 Homicide determined Hone mp 20906 Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Prostcians: To the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check -only one) Signature and title of certifie 29d. Date signed (Month, Day, Year) 28 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) autosbory Lin P mn

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Core Physician/ James Connors Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours (Month, Day, Year) Director 209-18-2539 1 XM 2 - F 85 Yrs. 12/6/1926 Old Forge, PA 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director or 28a-f Charles Waldorf 1 Yes 2X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral or items 23a 15201 Woodville Road 20601 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married MD0rS,  $J\alpha meS$  Baltimore, Maryland 21215-0036 1 Yes 2 No Specify d Mental Hygiene. marked other than "natural", If Yes, Give Specify: White 3X Widowed 4 Divorced Year or Dates any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Plumber Union Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Michael Joseph Connors Martha Williams Department of Health and Important: If item 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel E. Connors / Son 12665 Norwood Drive, Charlotte Hall, MD 20622 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Maryland Veteran Cemetery 4 Donation 5 Other (Specify) 10/11/2012 | Cheltenham, Maryland 21. Signatur of Funer A ervice-22. Name and Address of Facility Brinsfield-Echols F.H., P.A. #M00817 Fon 30195 Three Notch Rd., Charlotte Hall, MD 20622 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or beart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Pheumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner heart failure Orgestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to ior as a consequence of burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy jo in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown q Unknown P.O. | by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2 No certificate 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ٩ After this of funeral direction 1 Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Matural iniury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation Director: / d in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinio, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:07AM 1 AMES Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNAPOLIS AMO ANNE 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Hours Director 61 212-54-7576 1**X** M 2 □ F Yrs March 22 1951 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Examiner must be notified at Director 1 XYes 2 No Maryland Anne Arundel Annapolis o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 21401 USA 23 Dorsey Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black White etc. 1 Never Married 2 Married 0 à 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black "natural" 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Utility Mechanic BGE 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James S. Cooke Eleanora K. Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Md. 21401 Peggy Cooke (Wife) Dorsey Ave, Annapolis, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State injury or Bestgate Mem. Park 10/5/12 Annapolis, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary, 1922 Forest Dr. Annapolis, 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Vear 4 Pregnant at time of death Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by END STAGE KIDNEY DISDAGE, HYPE CTENSION 1 Yes 2 No 3 Probably 4 Unknown Records. 24b. Were autopsy findings available prior to completion of cause of MORRID OBESITY DIABETUS MELLITUS 24a. Was an death? SLEBP OBSTRUCTIVE 1 Yes 2 No \_ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be 1 Yes 2 No ဂ္ 1 Enpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 2 Accident 5 Pendina 1 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Pay, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PKWY, #607, ANNARCLI, MS 21401 2000 MEDICAL DEGAND State Registrar

DHMH 17 Rev 06-2011

ITEM 8 10/11/12 TF PER FH \_ AMEND ITEM 17 State of Maryland / Department of Health and Mental Hygiene For State Registrar 10/15/12 WCHD/JW PER FH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Regina Magdalene Cushwa Medical 2012 2:00 PM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 16014 Cloverton Lane Williamsport Washington Social Security Number If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. **Funeral** 7. Age (In yrs. last birthday) 8 Date of Birth 0690020 by 19922 Birthplace (State or Foreign Country) Director 180-16-1111 1 - M 2 XF 90 Usual Residence of Decedent 06/02/2012 Philadelphia, PA or 28a-f show 10a. State traumatic event, the Medical Examiner must be notified at **Funeral Director** 10c. City, Town or Location Washington Williamsport 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 16014 Cloverton Lane 21795 USA 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give than "natural". 1 Yes 2 X No Specify: 3 XWidowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 12 th Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John Joseph Cushwa, Sr. Fleming Regina Magdalene Lynch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, David A, Cushwa IV / Son 11222 Parkwood Drive Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 10/12/2012 | Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 North Potomac St., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) SQUAMOUS METASTATIC CARCINOMIA OF HEAT Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown signed by the a Day P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been signe page 2 should be MALNUTRITION HYPERTENSION, PAROXYTMAL Records, 1 Yes 2 No 3 Probably 4 Unknown FIBRILLATION. CERE LROVASCULTA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe DIVIDAGE 1 Yes 2 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of after death. Director: After 28c. Injury at 28d. Describe how injury occurred 1 Natural Pending ☐ Accident Investigation 1 ☐ Yes 2 ☐ No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital within 24 hours of To the Funeral C completely filled Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) CZ 138892 10/10/12 JUITE 130 of death (Item 23a) (Type, Print) 10 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month / 0 Day OS Physician/ lern yf. (00) AM Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution. give street and number, **Examiner** 4c. County of Death W. A Manylens attim cre d Social Security Number If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 206-66-8162 Hours Director 1 XM 2 □ F 29 Yrs Feb. 10,1983 Pennsylvania Usual Residence of Dec 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PA Franklin Waynesboro 1 🗶 Yes 2 🗌 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral 417 N. Church St. 17268 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 X Never Married 2 - Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify White 3 Widowed 4 Divorced Completed Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, Elementary/Secondary (0-12) College (1-4 or 5+) Chef School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Terry Francis Cool, Sr. Lois D. Dieterich permit, Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois D. Herchenrother-mother 334 Yorkshire Dr. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Rest Haven Cemetery Donation 5 Other (Specify) 10-12-2012 | Hagerstown, MD 22. Name and Address of Facility Douglas A. Fiery Funeral Home of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or hear failure. List only one cause on each line Immediate Cause (Final Onset and / ath Physician/ disease or condition resulting in death) temorrhage Medical Due to (or as a consequence of): Examiner Sequentially hat conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) law equires that the death certificate be executed Genetic and I-tran that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician a detached for use as the burial-Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Physician/ 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death Yes 1 ☐ Yes ∠ L g ☐ Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq Completed 1 Yes 2 No 3 Probably Unknown r this certificate has been signal director, page 2 should I 24b. Were autopsy findings available 24a. Was an prior to condeath? pletion of cause of performed? Hospital or Attending Physician: The 1 Yes Be ( 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospita Other: ျ 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Tyes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 0 MD

DHMH 17 Rev 06-2011

State Registrar Enc 5.
31. Date filed (Month, Day,

TW-8

6

702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Marv Clark :00P M 2012 Medical October 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Frederick 6404 Weatherby Ct. Apt. Frederick If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. **Director** 186-44-7150 1 🗆 M 2 🗶 F 98 2/19/1914 PA Usual Residence of Decedent 28a-f show ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No Frederick MD Frederick 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? Funeral USA 21703 6404 Westherby Ct.Apt D items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Examiner Black, White, etc. 0 þ 1 Never Married 2 Married 1 ☐ Yes 2 ▼No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", Specify: White 3X Widowed 4 ☐ Divorced Completed Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ould be filed within 72112, and Mental Hygiene.
is marked other than "r." avent, the Mer 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H is marked o 2 other traumatic John Roup Nora McCaffery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health as Important: If item 27 is any injury or other trau once. 6404 Weatherby Ct.Apt.DFrederick, Md. 21703 (Daugh ( Judith Evangelista 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Mt.Carmel Cemetery10/9/2012 Allegheny Co.PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Burket-Truby Funeral Home m1035 Allegheny Ave. Oakmont, Pa. 15139 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ TNEUMONIA disease or condition resulting in death) MONTH Medica! Examiner OBSTRUCTIVE PULMONARY DISEASE HRONIC Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Box 68760 attending ph d for use as the IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No s, outcome or pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (specify) 23d. Date of delivery Ectopic pregnancy Month Year Day the 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? by DEMENTIA Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed certificate Yes 2 No 1 Yes Division of Vital 25. Was case referred to-medical Be 26. Place of Death (Check only one) examiner? 2 🛂 No 1 🗌 Yes Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner eath 28a. Date of injury (Month, Day, Year) I Director: After to ad in by the funeral Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 52 WATER ST. , M.D State Registrar

			Type or Pri						-		_	э.	
	•	For State Registrar	Otato of Mi	ar yrarr		tificate			Workarri	Reg. N	2.0	2 3	372
Physicia	n/	1. Decedent's Name (First, Middle, Last)  TEOFILO FRANK	CORDOVA	Δ					2. Date of D		25,20°f2	3. Tim	e of Death
Medic Examin		4a. Facility Name (if not institution, give st 18601 Nuthatcher	reet and number)					ocation of Dea			c. County of De	ath	O I M
Funeral Director		5. Social Security Number 577-72-1529 6. Sex	7. Age	e (In yrs. la 83	st birthday) Yrs.	If Under 1 Months		If Under 24 Hrs Hours Min		ay, Year)	0	irthplace (Sta Country) Peru	te or Foreign
Maryland 28a-f show otified at	Funeral Director	10a. State 10b. County  Maryland Montgomer	У		therst								e City Limits Yes 2 X No
ith the	ralD	10e. Street and Number 18601 Nuthatcher I	ano			10f. Zip C		879			Ditizen of What C	-	
permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 🗶 Married	2. Was Decedent E Armed Forces? 1  Yes 24	Ever in U.S No	l If	Yes, specify	nt of Hisp / Cuban,	anic Origin? (S Mexican, Puer	specify Yes or No to Rican, etc.)		14. Race - Am Black, Wh	nerican Indian ite, etc.	,
eatural	leted	3 Widowed 4 Divorced	Year or Dates.			ent's Usual (			eruvian	16h	Specify: V Kind of Busines	White	
I within 72 Bygiene. her than "n It, the Medi	Be Completed	(Specify only highest grade	e completed) College (1-4 or 5	i+)	(Give k		done dur etired)	ing most of wo	rking		istribut		enter
uld be filed I Mental H marked ot maric even	To B	17. Father's Name (First, Middle, Last) Abraham Cordova						Maria (	me (First, Middle Celia Ga	rcia	3.		
d 2 sho alth and 1 27 is r er traur		19a. Informant's Name/Relationship (Type Richard G. Cordov							ural Route Numb e, Gaith				)
Page 1 and ment of He tant: If item tury or other		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State	C	lace of Disposemetery, crem	atory or other	er place) tery	20:		Ge	Location - City o		ı
permit Depart Impor any in		21. Signature of Funeral Service Licensee		1116)					eVol Fun Dr. Gai			MD 208	377
Physician/ , Medical Examiner		23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line	OST	ATE (			such as cardia	c or respiratory a	rrest,		Approxii Interval Onset a	Between
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infittated events resulting in death) Last	Due to (or as a										
ne death certific the attending properties to the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome  1  Live Birth 4  Pregnant at 9  Unknown	2 Fetal	I death 3	Ectopic pre Other (spec					23d. Date of d Month	elivery D <i>a</i> y	Year
luires that the signed by the detail	ed by Pr	Part II. Other significant conditions con	tributing to death b	ut not resu	ulting in the ur	nderlying car	use given	ı in Part I.			use contribute		A.
The law req ate has bee page 2 sho	Completed								24a. Was auto perf 1  Yes	opsy ormed?	prior to death?	utopsy finding completion es 2 \(\sigma\) No	
sician: certific irector,	Be	25. Was case referred to medical examiner?  1  Yes 2  No	ospital:				Other:	e of Death (Che	Δ.				-
nding Physath. : After this e funeral di	icate: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	1 ∐ Inpatie 28a. Date of injui (Month, Day	ry	ER/Outpatien 28b. Time of injury	1	:. Injury a work?		Home 5 Lines 28d. Describe			ecify)	
tal or Atter rs after decal Director	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc			et, factory, c	office		28f. Location ( City or To		nd Number or R e)	ural Route Nu	ımber,
the Hospi thin 24 hou the Funer mpletely fil	Medical	29a. Certifier (Check 2 Medical Examine only one) 3 Certifying Nurse	r: On the basis of ex	kamination	and/or investi	gation, in my death occurr	opinion, red at the	death occurred time, date and	at the time, date	and place the caus	se, and due to the se(s) and manner	e cause(s) <i>a</i> nd as stated.	manner stateo
O With		29b. Signature and title of cytifier  William William 30. Name and address of person who cor	1		00-1-7		D2	3308			ate signed (Mon		
		30. Name and address of persion who con VICTOR M. PRIEGU	MD 64/	eath (Item	23 <i>a</i> ) (Type, Pi	be dr	. B	ETITES	DA, MD	20	817		
Stat Registra		VICTOR M. PRIEGO 31. Date filed (Month, Day, Year) OCT 0 2 2012	39. Registra	ır's Sign <i>a</i> t	par	W.							

Registrar DHMH 17 Rev 06-2011

Registrar

State

31. Date filed (Month, Day, Year)

0 2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. Z Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Curry Eugene Charles Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Allegany Cumberland <u>WMHS-RMC</u> 8. Date of Birth (Month, Day, Year) Sep 3, 1957 Birthplace (State or Foreign Country). 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months MD **Director** 1**X** M 2 □ F 219**-**68-1330 55 Yrs ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 □ No Cumberland MD Allegany 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21502 14101 Winchester Road death v 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify: If Yes Give "natural", Completed 3 Widowed 4 Divorced white Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) Self-employed 12 aborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen White Jack Curry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12815 McMullen Hwy. SW MD 21502 Cumberland Kimberly Hite daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 10/3/2012 MD Scarpelli Funeral Home, P.A. Cresaptown Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA of Fun al Servic Licensee Signatul 108 Virginia Avenue: Cumberland, MD 21502 23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ramin Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, reading to immediate cause. Enter Underlying Cause (Disease or injury burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed' 2 🗆 No Yes 2 1 Tes this certificate filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 70131 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2500 Willow Brook Road Comberland MD -21502 CHO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

		For State Registrar		State of	Marylar	nd / Dep <i>Ce</i>		nt of Heate te of Deate		d Menta	, ,	iene	ขาา	2 3312	
Physician	,	1. Decedent's Name (First, Mi				_					te of Deat	h Day	Year	3. Time of Death	
Medica		Renly	Bru			nnis				Sep	tembe	er 29,	2012	2:05 A M	
Examine	er	4a. Facility Name (if not institu  St. Mary s	-					, Town, or Locard		ath			ty of Deat Mar		
Funeral		5. Social Security Number	6. Sex		7. Age (In yrs.	last birthday)			Under 24 F	rs. 8. Dat	te of Birth			hplace (State or Foreign	
Director		461-24-9182 Usual Residence of Decedent	1 🕱	M 2 🗆 F	90	Yrs.	Months		lours M		nth, Day, 17/	Year) 1922	Cou	Oklahoma	
and show	ģ	10a. State 10b. Cou	nty		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits	
or 28a-f show		Maryland S	t. Ma	ry's		Calif	ornia	1						1 🗌 Yes 2 🕱 No	
with the	Funeral Director	10e. Street and Number 44116 Louisd	ale R	oad			10f. Z	p Code <b>20619</b>			1	0g. Citizen o	What Co	untry?	
fter of amin	۾	11. Marital Status  1 Never Married 2 X 1 3 Widowed 4 Divor	Married	2. Was Deced Armed Ford 1 X Yes If Yes, Give Year or Dat	2 🗌 No		f Yes, spe	dent of Hispa cify Cuban, N 2 X No S	lexican, Pu	(Specify Yes erto Rican, e	s or No- etc.)		ack, White	rican Indian, e, etc. <b>Vhite</b>	
2 hou "natu	bet	15. Dece (Specify only hi	edent's Educi					ual Occupation		vorkina		16b. Kind of	Business	Industry	
thin 7 sne. than he Me	Completed	Elementary/Seconday (0-1	2)	College (1-4	1 or 5+)	life. D	O NOT us	e retired)	-	3	١,	Covern	mont	Contractor	
Hygie Other ent, th	a l	17. Father's Name (First, Midd	le, Last)	4		PT	ograi	Manag	•	lame (Firet		laiden Surnar		Contractor	
uld be fil Mental narked o	٥	Renly R.	De	nnis				10	Vada	, ,	Scot		110)		
2 shorth and the and the and traum traum		19a. Informant's Name/Relation										City or Town,			
Healf tem 2	ŀ	Christine D.  20a. Method of Disposition	Denni	s/Spou		Place of Dispo			2 KG.,	Date		ia, MD 20c. Location			
age 1 ent of nt: If i		1 🕱 Burial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Othe		emoval from S	State	cemetery, crei	natory or	other place)	_1 10				-		
permit. F Departm Importa any inju	ı	21. Signature of Funeral Service		4	1 (1)	arles						al Hom		wn, MD	
007 80	-	23a, Part 1, Enter the disease	// Complic	ckludy	used the dear								MD	20650 Approximate	
Physician/ Medical Examiner the pnual-transit	dical Examiner	23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to irras a consequence of):  Chamic behavior  Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):													
ath certification attending for use as	Me /												23d. Date of delivery Month Day Yea		
requires that the de been signed by the should be detached	2	Part II. Other significant cond	litions cont	ributing to dea	ath but not res	sulting in the u	ınderlying	cause given i	n Part I.	236	e. Did tob			the cause of death?	
requir	ete									-					
The law ate has page 2 s	Completed									-	a. Was an autops perforn Yes 2	y ned?	prior to o death?	opsy findings available completion of cause of	
ician: sertific ector,	e	25. Was case referred to medie examiner?	_	spital:				Othorn		neck only on					
ng Phys fter this can	are: 10	1 Yes 2 No  27. Manner of Death 1 Natural 5 Per		1 🗌 lr 28a. Date of	·	ER/Outpatier 28b. Time of injury		OA Other: 4 28c. Injury at work?	Nursing			nce 6 🗌 Otl w injury occur		fy)	
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	l certificate:										cation (Str / or Town,		per or Run	al Route Number,	
Hospit 24 hour Funera eted fille	Medical	(Check 2 L Medic	al Examine	r: On the basis	of examination	rledge, death on and/or inves	tigation, in	my opinion, de	eath occurre	d at the time	e, date and	place, and di	ue to the c	ause(s) and manner state	
To the within To the compl		29b. Signature and title of cert	ifier	1 1 A	alle nest of th	y knowledge, o		c. License nur		piace, and di		od. Date sign			
	-	30. Name and address of pers	P 100	pleted cause	of death (Iten	n 23a) (Tyne. F	Print)	DOU	1400	<i></i>		101	12		
+1 RML		6934 AVIC	NOKO	Blvd	. Suit	2 B 1	Gle	1 Burr	nie	MD	210	61			
State Registrar		31. Date filed (Month, Day, Yea OCT 0	2 201	2 37 Rec	gistrar's Signa	4. p									

Registrar DHMH 17 Rev 7/2009

7+1 RML

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30 Day Month **9** 2012 James Paul Doran 5:10 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>29935 Bolingbroke Lane</u> Trappe Talbot If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth **Funeral**  Birthplace (State or Foreign Country) Months Days Hours (Month, Day, Year) **Director** 555-46-8179 1 🔀 M 2 🗆 F 80 4-30-1932 CA 10a. State 10c. City. Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2 😾 No MD Trappe Talbot 10e. Street and Numbe Page 1 and 2 should be filed within 72 hours after death with the 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 29935 Bolingbroke Lane USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iter 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married <sup>2 □ №</sup>1955 Maryland 21215-0036 Yes Give 1 ☐ Yes 2 ☐ No Specify. Completed 3 Widowed 4 Divorced Specify: White Year or Dates 1974 Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Officer Military 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elmer E. Doran Mabel Oliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Bernette Doran/wife <u>29935 Bolingbroke Ln, Trappe, MD 21673</u> altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mid Shore Center 10-5-2012 Cambridge, MD Signature of Funeral Service Licensee 22. Name and Address of Facility 308 High Street Newcomb&Collins FHCambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Ph, sician/ Onset and Death MENTIA disease or condition Medical resulting in death) Tue to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) as the burial-transit Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical certificate be Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗆 Yes 2 🗹 No 3 🗀 Probably 4 🗀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed Yes 2 certificate 1 Yes 2 No or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No : After 28d. Describe how injury occurred 5 Pending Natural injury Accident Investigation within 24 hours after deat To the Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined the Hospital Medical 1 \*\* rettify! g Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 | edi | Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 | which is a physician of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only on 29b. Signature 29d. Date signed (Month, Day, Year) H54827 30. Name and andress of erson who completed cause of death (Item 23a) (Type, Print) EMIZEN (Type, Print)
PMIZENTON SCALE PLENTE WE SALEDWY, und BILIDEMAN W) 6 31. Date filed (Month, Day, Year) State

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death r 2<u>6 2012</u> Physician/ Irene Eldridge Avery 08:15 September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Walkersville Frederick Glade Valley Center If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral Director** 89 215-38-6000 1 M 2 X F July 25 1923 Virginia Usual Residence of Decedent 28a-f show at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Frederick Frederick MD 1 X Yes 2 No 5 10e. Street and Numbe 10g. Citizen of What Country?
United States 10f. Zip Code Funeral 21705 23a 5738 Box Elder Court items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc 0 Je filed within ...
rental Hygiene.
arked other than "natural", or
"...ont, the Medical Exam 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify. 3 ☒ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygien of Health and Mental Hygien fitem 27 is marked other th Own Home 6 0 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Welch Grace Mae Curtis Greer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 4024, Frederick, Maryland Geraldine Eldridge/Daughter 21705 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 and Department of Important: If ite any injury or ot cemetery, crematory or other place) 1 🗷 Burial Cremation 3 Removal from State 4 Donati 5 Other (Specify) Laytonsville Cem. 10/01/12 Laytonsville, MD 21. Signar re of Funer 22. Name and Address of Facility Barber Funeral Home Laytonsville, Maryland 20882 O. Box 5038, . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate k, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Physician Myocarclial Medical resulting in death) Examiner Sequentially list conditions, if any, additions, if any, additions, acause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as & consequence of) ig physician and as the burial-transit Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 23d. Date of delivery in the past 12 month 1 Yes 2 No for Month Day Year detached 1 ☐ Yes 2 

9 ☐ Unknown the 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Q Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **N** No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After t 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No neral Director: A Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cettifier 29d. Date signed (Month. Dav. Year) D43091 9-27-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grahenele, MD 21701 House Are TOIL Zanid 1 MI 801 Jacob 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 5:15 AM Medical Facility Name (if not institution, give street and number 1997)

Social Security Number 6. Sex 7 Examiner 4b. City, Town, or Location of Death 4c. County of Death KENSINGTON 10N+90men Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State of Foreign (Month, Day, Year 1 M 2 F Months Director 219-90-4704 Country) L Salvador 90 Nov. Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2911 Fenimore Road 20902 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify:White If Yes, Give ✓ Yes 2 No Specify: Salvadorean Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 School 5 Maintenance Housekeeper Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Isidro Espinoza Elena Flores 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria A. Reyes/Daughter 2911 Fenimore Road, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Oct. 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery <u>2012</u> Silver Spring, MD 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the reath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Due to (or as a consequence of): Physician/ Onset and Death disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last burial Physician/Medical that the death certificate be Box 68760 attending p IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? ☐ Ectopic pregnancy Other (specify) Pregnant at time of death Month Day Year 1 ☐ Yes 2 g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician: The law page 2 autopsy performe ☐ Yes 1 Tes 2 🗌 No 25. Was case referred to medical examiner?

1 Yes 2 No of Vital funeral director, Be 26. Place of Death (Check only one) Other: ೭ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending **M** Natural 5 Pending work?
1 Yes Division Accident
Suicide Investigation 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) ompleted filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 only one) Ecritifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

3000

iled (Month, Day, Year)

0 2 2012

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 11:17 A<sup>M</sup> Elsie Fallin October Rena Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death LaPlata Charles Genesis Health Care If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Min (Month, Day, Year) **Director** 1 - M 2 X F 578-10-8879 96 02/14/1916 Virginia show 10a. State 10b. County or items 23a or 28a-f sho miner must be notified at 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No Charles Maryland | Newburg 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 13300 Hill Road US 20664 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify White 'natural", 3 X Widowed 4 □ Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Homemaker event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H f item 27 is marked ot r other traumatic ever ည Page 1 and 2 should be Will Walls Delillah Hurley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Wayne W. Fallin/Son 29 Mullen Lane, Lothian, MD 20711 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or oth 20c. Location - City or Town, State Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery 10/06/2012 Suitland, MD 21. Sign num of Funeral Service Licey 22. Name and Address of FacilityBrinsfield-Echols F.H., P.A. ţ M00817 30195 Three Notch Rd., Charlotte Hall, 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Demonto disease or condition Medical resulting in death) **Examiner** 101/10 Sequentially list conditions, cause (Disease or injury that initiated events Exami burial-trar and Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 l g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 00 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: ဂ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural work? 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

Rme

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) roston 31. Date filed (Month, Day, Year) Registrar's Signaty

State Registrar

29a. Certifier

(Check only one

29b. Signature and title of certifier

asmall

1 dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Glan Burnie

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 8:30p.M Violet Mae FERGUSON 5, 2012 October /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Golden Living Center Hagerstown If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
May 28, 1922 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Country Maryland 1 □ M 2 🖾 F 90 214-32-3831 May Director Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene. Int: if Item 27 is markad othar than "naturef", or Items 23a or 28e-1 show 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is markad other than "naturel", or Items 23s or 28e-1 show other traumatic event, the Madical Examinar must be notified at Maryland Washington Hagerstown 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 539 Salem Avenue 21740 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Nidowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) homemaker- housekeeping hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Vernon Williams Mary Carpenter ၀ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Renner - daughter 311 Apt C North Colonial Drive, Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 6 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State October 8, Hagerstown Crematory 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licensee Depart Import eny in 415 East Wilson Blvd., Hagerstown, Maryland 21740 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Nec /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physicien and the burial-transit Division of Vital Records, P.O. Box 68760, certus Physician/Medical attending physic for use as the b IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 2 No 1 Yes 1 Yes To the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: ۵ 1 Yes 2No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After t Naturat 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 🕰 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of peraffier 29d. Date signed (Month, Day, Year) 35 8-1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OPAL ANVIR 1A3 HA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Oct 8, 2012 3:43 PM M Fairall Maxine Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany 207 Gleason Street Cumberland If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Country Apr 11, Yel 925 **Director** 213-24-5201 87 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location the Maryland 10d. Inside City Limits Director MD Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ō r items 23a or ner must be n 10g. Citizen of What Country? Funeral 21502 207 Gleason Street USA permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates. 3 XWidowed 4 Divorced Specify: Completed white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lucy Mary Weber Amos Abraham Monnette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 247 Massachusetts Ave. Cumberland MD 21502 Mary Sansler daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ✓ Cremation 3 L F 5 D Other (Specify) emation 3 - Removal from State St. Mary's Cemetery 10/13/201 MD Cumberland 4 Donation 21. Signature of Fun-22. Name and Address of Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or res, iratory arrest shock, of heart failure. List only one cause on such line.

Immediate Cause (Final Approximate Interval Between Ph, sician/ Onset and Death ave disease or condition Medical resulting in death) Due to (or as a c sequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events pue to for as a consequence on the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 88 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ate has been signed by the atterpage 2 should be detached for in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year Yes 2 No 1 Yes 2 Unknown Part II. Other significant conditions contributing to eath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 TNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? • Hospital or Attending Physician: The 24 hours after death. • Funeral Director: After this certificate h Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ည 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check within 2 only one State 19 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:50 p.n. Francis Gabrelcik September Robert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Prince Frederick Calvert Memorial Hospital 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Hours (Month, Day, Year, Months 468-20-1138 Director 1 🔀 M 2 🗆 F 05/19/1922 Usual Residence of Deceder 90 Minnesota show 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location with the Maryland notified at Director 28a-f 1 Yes 2 X No Maryland St. Mary's Lexington Park 10g. Citizen of What Country? ms 23a or must be r 10e. Street and Number 10f. Zip Code Funeral 20653 United States 23540 River Road death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ŏ þ 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) event, the Real Estate Developer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of the and Mental H 27 is marked of traumatic ever မ John Gabrelcik Mary Polinga 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Joyce K. Gabrelcik/Wife 23540 River Road, Lexington Park, MD other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department o Important: If any injury or once. ± 5 4 Donation 5 Other (Specify) Brinsfield-Echols Cre 10/02/2012 Charlotte Hall, MD Signature of Juneral Mercenson Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Cardio vasivias disease Attreroscienatic disease or condition resulting in death) Medical **Examiner** Hypentensive Dequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? signed by the atte Day Year Month Ves 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Demen Ha 24b. Were autopsy findings available prior to completion of cause of death? Dysphayia 24a. Was an autopsy performed Fibrillation 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Npatient 2 ER/Outpatient 3 DOA မ this funeral 28c. Injury at work? 1 🗌 Yes 2 🗎 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: A Natural 5 Pending after death. the f Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 - Homicide 24 hours a Funeral I Medical

Rme State

within 24 hor

To the Fune

completely f

5851 Deale ROUCI 31. Date filed (Mor 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUNO

Registrar

29a. Certifier

(Check

29b. Signature and title of certifier

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D 50653

ayan

29d. Date signed (Month, Day, Year)

SURANA

10-1-2012

20757

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JEANETTE E. HOPKINS SEPTEMBER 2012 12:55 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1727 FOUNTAIN ROCK WAY, UNIT B **EDGEWOOD** HARFORD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) - 1<u>930</u> Months Hours Min. (Month, Day, AUG. 24 Country)
NEW YORK 82 129-22-2498 Director Usual Residence of Decedent show or 28a-f shov notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland 10a, State Director HARFORD **EDGEWOOD** 1 🗌 Yes 2 🔀 No MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 21040 UNITED STATES 1727 FOUNTAIN ROCK WAY, UNIT B "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: BLACK Completed 3 Widowed 4 X Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry ed other than " event, the Mer Elementary/Seconday (0-12) College (1-4 or 5+) NURSE HOSPITAL Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ EDWARD E. STANSBURY, SR. MARY GARLETHIA DUNGEE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21078 1130 CHESAPEAKE DRIVE, APT 15C, HAVRE DE GRACE, MD MARY F. CROWE / SISTER Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) ROCKLAND CEMETERY 10/06/2012 SPARKILL, NEW YORK . Signature of Funeral Service Licenses d Address of Facility LISA SCOTT FUNERAL HOME, P.A. 552 LEWIS STREET, HAVRE DE GRACE, MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Myoc Physician/ ardi disease or condition Medical resulting in death) Due to (or s a consequence of **Examiner** Sequentially list conditions Examiner Due to or as a consequence of: if any leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death detached 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was an autopsy performed? certificate has page 1 ☐ Yes 2 ☐ No Yes 2 ours after death. eral Director. After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{E}\) Residence 6 \(\sum \) Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [ 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) D58888 MD e and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Jamshid M 31. Date filed (Month, Day, Year) 4863

32. Registrar's Signature

			FiedSe	State of Marylar						-		_	ibie.		
			For State	State of Marylar		tificate			and iv	іентаї пу		21	112	33	72
			Registrar  1. Decedent's Name (First, Middle, Last)			uncate	טוט	eaur		2. Date of De	Reg. N	0.	116	<u> </u>	13
	Physicia		3	ames Lotzie He	orczog					Month	Day Year				
· and	Medic Examin		4a. Facility Name (if not institution, give si		erczeg	4b. City, To	wn. or l	Location o	of Death	Octobe	-	c. County		2123	Γ
	_xaiiiii		Herron Creek			, · · ·		East				Cec			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1		If Under	24 Hrs. Min.	8. Date of Bir (Month, Da		9. Birthplace (State or Foreign Country)			Foreign
	Director			]м2□F 69	Yrs.	Months	Days	Tiouis	IVIIII.	NOV 18				ryland	
	nd how at	5	Usual Residence of Decedent  10a. State 10b. County		ty, Town or Loc	cation				1101 10	, 1	742		Dd. Inside City	/ Limits
	laryla 3a-f s iified	ect	Maryland Cecil		E1kton									1 Yes	2 👿 No
	or 2	₫	10e. Street and Number			10f. Zip C	ode				10g. C	itizen of V	Vhat Coun	try?	
	rth with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	135 Landside Lane			21	921				1	Unite	ed Sta	ates	
	death item ner n			12. Was Decedent Ever in U.S Armed Forces? 106	S. 13. V	Vas Deceden f Yes, specify	nt of His	panic Orig	gin? (Spe	cify Yes or No- Rican, etc.)			e - America k, White, e		
36	rs after deat ıral", or iten Examiner ı	d by	Never Married 1 AYes 2 No 100/												
9	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Completed	15. Decedent's Edu	Year or Dates.		lent's Usual C	Occupat	tion			165		Whi:		
215	n 72 h an "n Medi	ᇤ	(Specify only highest grade Elementary/Secondary (0-12)		(Give I	kind of work of NOT use re	done du	iring most	of workir	ng	100.1	KING OF BL	isiness/inc	ustry	
21	l within 72 /giene. ner than '		2	College (1-4 of 3+)	Self	-emplo	yed	Truc	ck Di	river		Truc	king		
pu	illed i otl	To Be	17. Father's Name (First, Middle, Last)							(First, Middle,	Maiden	Surname	)		
yla	should be file and Mental F is marked o aumatic eve	-	Michael Lotzie He						_	Bednar					
Maryland 21215-0036	Shouth and 7 is nutraum		19a. Informant's Name/Relationship (Type		1					Route Numbe			tate, Zip C	ode)	
	ge 1 and 2 should be intof Health and Ments: If item 27 is marked or other traumatic e		Nancy B. Herczeg/		135 L			1		on, MD		1921	City or To	un Ptoto	
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or of		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	emetery cren aculat ceptio	natory or othe	er place,	) [	Octo	ber 16,	200. L				`
計	artme vartme ortar injur		21. Signature of Funeral Service Licenses		cept10	n Ceme	Address	y 2	2012 Hid	cks Hom	e f			ill, MI 1s P	
ä	Depar Impol any ir		(1) and S.	Hickory	- 4					Street,				21921	
9	Medical Examiner		23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cations that caused the deat cause on each line.  Due to (or as a consequ		er the mode o	of dying,	such as o	cardiac or	r respiratory an	rest,			Approximate Interval Betw Onset and De	
	be executed sician and burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a) consequence to (or as a consequence to (or a) consequence to (or a) consequence to (or a											
092			d										-		
. Box 6876(	The Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  The funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 28b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregna 1  Live Birth 2 Feta 4  Pregnant at time of o	al death 3 🗌	Ectopic pred Other (speci						23d. Dat Mor	e of delive	ry Day Ye	ar
P.0	that the	y PI	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cau	ise give	n in Part I.		23e. Did to	bacco	use contr	bute to the	e cause of dea	ath?
ds,	quires en sig ould b	ed								1.1	Yes 2	□ No	3 🗌 Prob	ably 4 🗌 Ur	nknown
Records,	law has je 2	Comple				<del>-</del> .				24a. Was autop perfo 1  Yes		l p	Vere autop rior to con eath?	sy findings avan pletion of cau No	ailable use of
tal	ician; sertific	m	25. Was case referred to medical examiner?	ospital:			26. Plac	e of Deat			30			A soi ot o	
Ž	Physical direction	9	1 ☐ Yes 2 No	1  Inpatient 2	ER/Outpatien 28b, Time of			4 ∐ Nui		ne 5 Resid			. 100001197	Aesist (	şu •
0	ding th. After fune	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	M 280.	. Injury a work? 1 □ v		- 1	8d. Describe h	ow injui	ry occurre	d		
Division of Vital	The land the Hospital or Attending Physician; The la within 24 hours after death.  To the Funeral Director; After this certificate ha completely filled in by the funeral director, page	Certificate:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre			03 2 2	-	8f. Location (S City or Tow			r or Rural I	Route Number	;
_	lospit 4 hour unera ely fille	Medical	29a. Certifier 1 Certifying Physic 2 Medical Examine	cian: To the best of my knowler: On the basis of examination	ledge, death o	ccurred at th	e time,	date and p	place, and	d due to the ca	ause(s) a	and mann	er as state	d.	er etatad
	the F thin 24 the F mplet		only one) 3 Certifying Nurge	Practitioner: To the best of n	ny knowledge,	death occurre	ed at the	time, date	e and place	e, and due to t	he caus	e(s) and m	anner as st	ated.	or stated.
	<b>6 a a</b>		29b. Signature and title of certifier	W	110	29c. Li	icense r	number	10-		29d. Da	ate signed	(Month, D	ay, Year)	
	الغد		20 Name and address of	<u>//</u>	P(1)		<u>VC</u>	062	190	/ 14-0 ::	A . 10	0/1	4/10		
	5 V Stat		30. Name and address of person who cor 3533 AUGUST 31. Date filed (Month), Đay, Year)	TINE HERMAN  32. Secretary's Signate	N Hwy	SHA SULT		A	CHE	SAPE	AIC	E Ci	ty,	MD 219	115.
	Registra		OCT 1 9 201	2 Dema	1. 60	Mas									

DHMH 17 Rev 06-2011

DHMH 17 Rev 06-2011

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Corrhon Redman-F	1	- For State	ate of Maryla		tment of ficate of		and	Menta	al Hyg		eg. No. 2	n I	2 3373
Physician/ Medical Examine	7	egistrar I. Decedent's Name (First, Middl Corrhon R	e,Last) <b>edman-Pat</b> i Redma	rick Harp	per Patri	ok I	Harr	er.		Date of Deat Month October 7,	h Day Yea		3. Time of Death 1100 hrs
	4	4a. Facility Name (if not institution 513 Rosehill Avenue	n, give street and nu	ımber)	1	4b. City, Town Cumberl		cation of I			4c. County of Allegany		
Funeral Director	-1	5. Social Security Number 216-37-4705	6. Sex	7. Age (In yrs. las	t birthday) Yrs		Year Days	If Under 2 Hours	2.01	8. Date of Birt 10/21/	h(мм/DD/YYYY 1992	Foreig	hplace (State or Maryland Intry)
i ow any	1	Usual Residence of Decedent 10a. State 10b. County 10b. All	egany		own or Locati								10d. Inside City Limits 1 X Yes 2 No
the Maryland a or 28a-f show any tified at once. Director		10e. Street and Number 513 Rose Hi				10f. Zip Coo		502		10	Og. Citizen of Wh	at Coun	try?
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other thun "natural", or items 23a or 28a-f sho injury or other traumantic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	-	11. Marital Status 1 X Never Married 2 M 3 Widowed 4 Div	arried Armed Forced If Yes, Give Yes	2 X No	lf Y	s Decedent of es, specify Cu	ıban, M	lexican, P			14. Race White Specify:	, etc.	ean Indian, Black, Black
5-0036 ed within 72 hours afted within 72 hours afted within 72 hours afted the form "matural" the Medical Examine Completed by	-	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12	or Dates:	de completed) 1	6a, Deceden during m	t's Usual Occi ost of working istant	upation life, Do Mat	(Give kir 0 NOT us nage 1	se retired	)	16b. Kind of Bu Resta	aura	nt
21215-0036 ould be filed within 7 ould be filed within 7 in Mental Hygiene. in marked other than ic event, the Mediu To Be Compile	3	7. Father's Name (First, Middle, Patrick	LaVon	Me	ade, J		_				I Maiden Surname 1e I		
MD 21 32 should the and Me as 77 is ma numatic co	I	19a. Informant's Name/Relations Daniel B. Harpe			186	Tather	Ro	ad, I	Mart	insbur	ber, City or Tow g, WV	2540	5
Baltimore, MD bemit. Pages I and 2 sho peratment of Health and important: If item 27 is injury or other traumati	l	20a. Method of Disposition  1 X Burial 2 Cremation  4 Donation 5 Other Sy	pecify:		matory or oth Mary 1	ition (Name of ner place) s Ceme	ter	у	10/1	2/20 <b>1</b> 2		erla	nd, MD
	(	1./Signature of Funetal Service	lares		40	4 Deca	tur	Str	eet,	Cumbe	rland, 1	MD	Home, P.A. 21502
Physician /Medical Examiner		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each line. a. <b>Cardia</b>	c Arrhyth		ne mode of dy	ring, su	ch as card	diac or re	espiratory arre	est, shock, or hea	art	Approximate Interval Between Onset and Death
		or condition resulting in death) Sequentially list conditions,	b Myocard	consequence of):	cosis								
ted nsit <b>Examiner</b>		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	a consequence of):		_							
be executed ician and unial - transit		X UNPENDED	d.	1,23a,27,	per me	2933	11-	-29-1	2 sı	<u> </u>			
ox 6876( ath certificate attending phys or use as the b	1 2	F FEMALE: 3b. Was decedent pregnant in the past 12 months?	23c. If yes, 1 Live b	outcome of pregna birth nant at time of deat	ancy 2 Fe	tal death		Ectopic p			23d. Date of Month		ay Year
P.O. Bores that the designed by the be detached for both by the bed by the by the by Phy	3	Part II. Other significant condit	ions contributing to	o death but not res	ulting in the u	ınderlying cau	ıse give	en in Part	1.		bacco use contri		he cause of death? ably 4 Unknown
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach ledical Certification: To Be Completed by P.	and line									24a. Was a autop perfor	sy p m <u>ed</u> ? d		opsy findings available ompletion of cause of S
sician: sician: is certifi lirector,	3	25. Was case referred to medica examiner?	Hospital:	Inpatient 2 E	R/Outpatient			Death (C			Residence 6	Other:	Scene
tending Physeath.  or: After this the funeral di	٠ ١٠	1 Yes 2 No  27. Manner of Death 1 X Natural 5 Pend 2 Accident Inve		of Injury n, Day,Year)	28b. Time of I	njury 28c.	_ `	at Work?		3d. Describe h	now injury occurr	ed	
Division O  Propital or Attending 24 hours after death Francial Director: Aftered filled in by the fune		3 Suicide 6 Cou 4 Homicide dete		ce of Injury - At hom	ne, farm, stre	et, factory, offi	ice buil	ding, etc.	28	or Town, S		er or Ru	al Route Number, City
To the Hosy within 24 hc To the Fun completely Medical C		(Ollech Oll)	hysician: To the beaminer:On the basis and manner s	of examination and									
m s H o		29b. Signature and title of certific				29c. Lio	.C.M.				29d. Date signe October 9,		th, Day, Year)
		30. Name and address of persor Donna M. Vincenti, M	D Assistant A	Medical Exami	ner 900	W. Baltim	ore S	treet, B	Baltimo	re, MD 21	223		
Stat Registra		31. Date filed ( <i>Month, Day</i> , Year)	2 h 32. R	egistrar's Signature	barled	•							
DHMH 17 Rev 1/2001	1		Maria	1. 19	ORIGINA	L							

12-07535 William Ray Harrei	11		or Print in Bi							0 0070
William Nay Haire	1	For State Registrar	e or iviaryland	•	ificate of		iu ivieritar		eg. No.	12 3373
Physician Medical Examine	1	1. Decedent's Name (First, Middle,L William Ray Hart						Date of Dea     Month     October 5		3. Time of Death 0438 hrs
Medical Examine		4a. Facility Name (if not institution, of Doctor's Community Hos	give street and number)			4b. City, Town, o	or Location of Dea		4c. County of Dea	ith
Funeral Director		220-02-6832	Sex 7. Ag	e (In yrs. Ias	st birthday) Yrs	If Under 1 Ye Months Da		8. Date of 8i lin. Feb. 12	rth(MM/DD/YYYY) 9. E Fore 2,1967	
Aaryland 28a-f show aoy Lat once.	l	Usual Residence of Decedent 10a. State 10b. County Maryland Prince	George's	10c. City, T Lanh	own or Locat	ion				10d. Inside City Limits  1 Yes 2 No
the Maryland a or 28a-f sh tified at once		10e. Street and Number 7314 Cipriano Spi	rings Drive			10f. Zip Code 20706			Og. Citizen of What Co United St	
or items 23.	I I	11. Marital Status 1 Never Married 2 Marri	12. Was Decedent Armed Forces? 1 Yes 2	Ever in U.S	If Y	es, specify Cuba	n, Mexican, Pue	Specify Yes or No rto Rican, etc.)	14. Race - Ame White, etc.	erican Indian, 8lack,
irs afte	3-	3 Widowed 4 Divorce  15. Decedent's Education (Specify	ed If Yes, Give Year or Dates: only highest grade com	pleted)	16a. Deceder		ation (Give kind o		16b. Kind of 8usines	
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after no f Health and Mental Hygere. tt If Item 27 is marked other than "oatural", other traumatic event, the Medical Examiner To Re Commissed by	ואומנט	Elementary/Secondary (0-12)	College (1-4 or		_	ost of working lift $mployed$	e. DO NOT use r	etired)	constru	ction
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than sum atte event, the Medis	ן צ	17. Father's Name (First, Middle, La William Ray Hari	rell, Sr.		Liou		Geneva	Woody	Maiden Surname)	
MD 21 2 should h and Me 27 is ma matic cv	2	19a. Informant's Name/Relationship Noreen Harrell							nber, City or Town, Sta Lanham,Ma	ryland 20706
Baltimore, Nemit Pages I and Department of Health Important: If item iojury or other trau		20a. Method of Disposition  1 Burial 2 X Cremation  4 Donation 5 Other Spec	_	to cr	ematory or oth	ition (Name of co herplace) tan Crei		Date .0/6/2012	20c, Location - City of Alexandri	or Town, State a, Virginia
Baltin permit. P Departme Importan iojury or		21. Signature of Funeral/Service Lic	ensee		350 44	lane ind Address 00 Powde	ss <b>Borgw</b> ar er Mill	dt Funer Road Bel	al Home, P tsville, M	A aryland 2070
Physician /Medical	4	23a Part I. Enter the disease, or confailure. List only one cause or Immediate Cause (Final disease	moin ations that caused each line.  aNarcotic (					c or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a conse		u) inc	OXICALIC	<u>ли</u>			
in a second		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of)						
executed ian and ial - transit	LYa	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse							
be executed sician and surial - trans			x AMENDED#1as			pt.II,2	7.28a-f,	per me,g		
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physiciao: The law requires that the death certificate be within 24 hours after death.  To the Fuorral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buritical Certification: To Be Completed by Directorian/Medical		IF FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkno	23c. If yes, outcon  1 Live birth  4 Pregnant at  9 Unknown		2 Fe	etal death 3 her (Specify)	Ectopic preg	nancy	23d. Date of delive Month	ery Day Year
ires that the de ires that the de ir signed by the detected for the detect		Part II. Other significant condition		n but not res	ulting in the u	underlying cause	given in Part I.		obacco use contribute t	
Records, P.( The law requires tha ficate has been signed , page 2 should be det	ומר	Cocaine Use, Ca	ardiomegaly					24a. Was	an 24b. Were a	obably 4 🗹 Unknown autopsy findings available completion of cause of
Vital Records, ysiciae: The law requir his certificate has been i director, page 2 should					_			perfo 1 <b>✓</b> Yes	omed? death?	
is certif		25. Was case referred to medical examiner?	Hospital: 1 Inpatie	nt 2 🗸 E	R/Outpatient		Other Nur		Residence 6 Oth	er:
ding Physic  L After this funeral dir	-  -	1 ✓ Yes 2 No  27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju (Month, Day,Y	ry :	28b. Time of I	njury 28c. Inj	ury at Work? Yes 2 X No	28d. Describe	how injury occurred	
Division of Napital or Attending Phorurs after december overal Directors. After the filled in by the funeral Contification.	LIICAL	2 Accident Investig 3 Suicide 6 X Could n determi	ot be 28e. Place of In	jury - At hor		et, factory, office		28f. Location ( or Town, S	Street and Number or F	Rural Route Number, City
Divisior  To the Hospital or Attend within 24 hours after death virtue to the Fuoeral Director: completely filled in by the indival Contification	CE	4 Homicide  29a. Certifier 1 Certifying Physicians (Check only)	(Specify)  Ician: To the best of mer:On the basis of example 1	y knowledge	e, death occur			nd due to the cau		
To the Ho within 24 1  To the Fu  Completed	Dale	29b. Signature and title of certifier	and manner stated.	1		29c. Licen	ise number		29d. Date signed (M October 5, 2012	onth, Day, Year)
· ·	-	30. Name and address of person wh						MD CASE	I	
		Zabiullah Ali, M.D. As	sistant Medical Ex	kaminer	900 W. E	saltimore Str	eet, Baltimor	e, MD 21223		

Registrar DHMH 17 Rev 1/2001 OCME 2006

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician/ 3:15 P 2012 Hanson October Daniel Roger Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. Mary's Charlotte Hall Veterans Home Charlotte Hall 8. Date of Birth 6. Sex 1 X M 2 □ F Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** New York Months Days Hours 10/8/1923 88 Director 096-12-3101 Usual Residence of Decedent or items 23a or 28a-f show miner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State filed within 72 hours after death with the Maryland Director 1 Tes 2 No Collier Naples Florida 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral S 9411 Quarry Drive 34120 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White "natural", 3 ▼ Widowed 4 □ Divorced or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Architecture 6 Architect Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lilla Johnson Anton Hanson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9411 Quarry Drive, Naples, Florida Cathy Anderson/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 Department of Important: If it any injury or o 1 D Burial 2 K Cremation 3 D Removal from State Brinsfield-EcholsCrem. 10/08/2012 | Charlotte Hall, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. Sign ture of Funeral Service Licensee MOO817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between Onset and Death Immediate Cause (Final CARDIAC ARRHYTHMIA Phytician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner IDNEY HRONIC Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine HYPERTENSION SSENTIAL physician and the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician after use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> ERLIPIDEMIA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 🗆 Yes 2 🗆 No 1 ☐ Yes 2 ☐ No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 110 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Certificate: work? 1 Natural injury 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2012 D0067788 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOPALI RAO 29449 Charlotte Hall Rd., Charlotte Hall, MD 20622

5+ ene State Registrar

31. Date filed (Month, Day, Year)

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle 1 ast) 2. Date of Death Physician/ Day 2012 Rosalie Concetta Husmann October 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospice House of St. Mary's St. Mary's Callaway If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign Hours Min. Director 096-18-8093 1 🗆 M 2 🖾 F 87 Usual Residence of Decede 03/20/1925 New York item 27 is marked other then "naturel", or items 23e or 28e-f show other treumatic event, the Modical Examiner must be notified at 10a State 10b County filed within 72 hours efter death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland St. Mary's California 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 44124 Louisdale Road 20619 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 ANo
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 h
Department of Health end Mental Hygiene.
Importent: If item 27 is marked other then "ne eny injury or other treumatic event, the Medic once. 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Civil Servant Civil Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mario Granata Rosalia Geradino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marston E. Husmann/Husband Box 180, California, MD Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Brinsfield-Echols Cre 10/11/2012 Charlotte Hall, MD Karnieen Santivasci M00872 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical to (or as a consequence of) Examiner E-quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner as a consequence of: To the Hospital or Attending Physicien: The fear sequence within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pege 2 should be detached for use as the burial-transit Hospital or Attending Physicien: The lew requires that the deeth certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 🖾 Other (Specify) Hospital: 2 X No <u>م</u>| 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1X Natural 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Hornicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one)

6 Rme State

Registrar DHMH 17 Rev 06-2011 Michael

31. Date filed (Month, Day, Year)

S.

ted cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

29c. License number

22590 Shady Court, California, MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

3. Time of Death

1123

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2X No

MARYLAND

2012

Black, White, etc.

State Registrar 31. Date filed (Month, Day, Year)

1 N S+1

1 - For State Registrar

		Pleas	se Type or Prin		nd / Departme					0	ible.		
		For State Registrar	State of Ma	ii yiai	Certifica			ivientan	Reg. N	0	012	2271.	
		DeGedent's Name (First, Middle,	Last)		11	1	- Cutt	2. Date of	Death	-		3. Time of Death	
Physicia Medic		Kogen			Hau	pt	•	Octobe		4 20	Year (2/2 (	6:26 PM	
Examin	er	1 he Johns Ho	give street and number)		4b. Ci	Town, or	Location of De	ath	4	c. County	of Death		
Funeral		5. Social Security Number	Sex 7. Age	n yrs.	last birthday) If Und		If Under 24 H Hours Mi		Birth Day, Year)			e (State or Foreign	
Director		217-82-8588 Usual Residence of Decedent	1 □ <b>X</b> ⁄⁄⁄⁄⁄ 2 □ F		<b>50</b> Yrs.	Days	Hours		22,1		Mary	land	
and show	or	10a. State 10b. County		10c. Ci	ty, Town or Location						10d.	Inside City Limits	
Maryl 28a-f otifie	irec	Maryland Washir	ngton	В	Boonsboro							1 🗌 Yes 2 🕱 No	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 21514 Mt. Lena	Road			Zip Code 21713			10g. (	U.S.	/hat Country?	?	
eath w	-une	11. Marital Status	12. Was Decedent Ev	er in U.	.S. 13. Was Dec	edent of Hi	spanic Origin?		No-		e - American I	ndian,	
after d ", or i	þ	1 Never Married 2 Marrie	Armed Forces?  1 Yes 2 1	lo		ecity Cubai	n, Mexican, Pue Specify:		Black Specify:	k, White, etc. <b>whit</b>	te		
atural	Completed	3 Widowed 4 Divorced	Year or Dates.		16a. Decedent's Us				16h		siness/Indust	try	
in 72 h e. nan "n	duic	(Specify only highest Elementary/Secondary (0-12)		-)		ork done d	uring most of w	rorking	100.	KING OF BU	13111C33/111CU31	ау	
d withi lygiene ther th	Be Co	12	0	,	plumbir	g					uction	1	
be file ental H ked ot c ever	To B	17. Father's Name (First, Middle, La Roger Le	ee Haupt				18. Mother's N	lame (First, Mid June	<sup>dle, Maider</sup> Powe		)		
hould and Mi is mar		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing Addre	ss (Street a	and Number or I	Rural Route Nui	nber, City o	or Town, St	tate, Zip Code	=)	
lealth a m 27 in tra		Diane L. Haupt	- wife		21514 M		na Road	d, Boor					
ige 1 a nt of H t: If ite		20a. Method of Disposition  1 Method of Disposition  2 Cremation 3			Place of Disposition (N cemetery, crematory of	other place	1 00	tober 9 2012			City or Town,		
nit. Pa artme ortani injury		4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service Lic		N	1t. Lena C		s of Facility				al Hom	aryland	
permil Depar Impor any in		Valuat BO	Parkin				/ilson B						
Physician/		23a. Part 1. Enter the disease, or c shock, or heart failure. List on Immediate Cause (Final disease or condition	ly one cause on each line.	. 1					y arrest,		Int	proximate erval Between iset and Death	
Medical Examiner		resulting in death)	Due to (or as a	consec	Juence of):		-57101-	7					
	ner	1 Clert Com											
be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	. Cinho:	513		der var helle er Wille besselvert							
e execcian al	cal E	resulting in death) Last											
cate b physi			d										
eath certificate b attending physic d for use as the b	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			c pregnance	· ·			23d. Date	e of delivery		
death the attr	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at 9 Unknown				,		-	Mon	ith Day	/ Year	
requires that the des been signed by the s should be detached	by Physician/Medi	Part II. Other significant condition	s contributing to death bu	t not re	sulting in the underlyin	g cause giv	en in Part I.	23e. D	id tobacco	use contri	bute to the ca	ause of death?	
uires t in sign uld be								1	☐ Yes	No No	3 Probabl	y 4 🗌 Unknown	
aw req as bee 2 sho	Completed							24a. V	/as an utopsy			findings available etion of cause of	
sician: The law i certificate has b lirector, page 2 s	Corr						_	_ p	erformed?		eath?	] No	
Physician:   this certifice eral director, p	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:			0.11	ace of Death (C/						
g Physer this leral di	е: То	27. Manner of Death	28a. Date of injury	1	ER/Outpatient 3 28b. Time of	28c. Injury	4 LJ Nursing	Home 5 F					
ending sath. or: Afti she fur	ficat	1 Natural 5 Pending 2 Accident Investiga	ation	rear)	injury M	work	? Yes 2□No						
or Att	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin			ome, farm, street, factory)	ory, office			n (Street a Town, Stat		r or Rural Rou	ıte Number,	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans	Medical (	29a. Certifier 1 Certifying F	Physician: To the best of m	ıy know	vledge, death occurred	at the time	, date and place	e, and due to th	e cause(s)	and manne	er as stated.		
the Ho nin 24 I the Fu gpletel	Med	(Check 2 Medical Ex	aminer: On the basis of exa lurse Practitioner: To the	aminatio	on and/or investigation,	n my opinio	n, death occurre	d at the time, da	te and plac	e, and due	to the cause(s		
PFF		29b. Signature and title of certifier	A		i	9c. License			1 -		(Month, Day,	,	
5		30. Name and address of person wi	o completed cause of de	ath (Iter	n 23a) (Tvpe, Print)	KK	2000		100	tobe	er 0	21287	
		Souvik CI	natteriel		00 ORL	eans	Stre	et Bo	Atin	ione	Mary	4 2012 21287, iLand	
Stat Registra		31. Date filed (Month Day-Year)	2012 32. Registrar	's Signa	ature	1							

				State of M					Mental Hygi	•			
			For State Registrar	Otate of Ivi	-	•	te of De			eg. No. 201	2 33745		
			Decedent's Name (First, Middle, L.)	.ast)			10 0. 50		2. Date of Death	1	3. Time of Death		
	Physicia Medic		Sidney	Morris	HOR	OWITZ			Septembe	r <sup>D</sup> 27, 201′2	6:30 Р. м		
	Examin		4a. Facility Name (if not institution, g					cation of Death		4c. County of Deatl			
كبد			Hebrew Home of G				ckvill		T	Montgo			
	Funeral Director		086-26-5938	Sex 7. Age 1 X M 2 □ F	(In yrs. last birtho	I Months		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) Cou	hplace (State or Foreign Intry) York		
			Usual Residence of Decedent						June 22	, 1935 New	10110		
	yland -f shc ed at	당	10a. State 10b. County Maryland Montgom	orv	10c. City, Town o						10d. Inside City Limits		
	e Mar r 28a notifi	Die.	Maryland   Montgom	er y	DC 6110	1-200	lip Code		- 1.	0.00	1 ☐ Yes 2 💢 No		
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho Aedical Examiner must be notified at	Funeral Director	7401 Westlake Te	rrace #602			20817		- II	og. Citizen of What Co United St	ates		
	tems er mu	ᆵ	11. Marital Status	12. Was Decedent B	ver in U.S.	13. Was Dece	edent of Hispa	anic Origin? (Sp	ecify Yes or No-	14. Race - Amer	ican Indian,		
36	ifter d ", or i amin		1 Never Married 2 Marrie	Armed Forces?  1 Yes 2 X	No			Mexican, Puerto	Hican, etc.)	Black, White	hite		
Š	ours a	et	Year or Dates.										
15	72 h	힐	(Specify only highest				ork done durii	ng most of wor	king I	66. Kind of Business I nterstate	Commerce		
212	within giene.		Elementary/Seconday (0-12)	Commissio	n								
nd	e filed tal Hy ed oth event	To Be	17. Father's Name (First, Middle, Las	aiden Surname) Pettscheide									
र्ड	should be file n and Mental I 7 is marked o raumatic eve	-	Joseph Ho  19a. Informant's Name/Relationship	rowitz				Sylv					
			Paula Risin Horov		740	Mailing Addre	ss (Street and Take To	errace,	#602, Bet	City or Town, State, Zip Chesda, MD	20817		
re,	permit. Page 1 and 2 Department of Healti Important; If item 2 any injury or other t		20a. Method of Disposition		20b. Place of D	isposition (Na	ame of	1		Wp. Of Was			
Ē	Page nent d ant; If ury or		1  Burial 2  □ Cremation 3 4  □ Donation 5  □ Other (Spe		Beth El	Ceme to	ery	9/30		Rergen Cour			
3alt	ermit. eparti nport ny inj		21. Signature of Funeral Service Lice	ensee /		22. Name a	and Address o	of Facility T	orchinsky	Hebrew Fu	ineral Home		
	<u> </u>	- 78	muchel O	1 2yeu	Mar Land Daniel			1/		ngton, DC 2			
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final	one cause on each line				sucri as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death		
	h i i n Medical		disease or condition resulting in death)	a. PNE	consequence of):	MIE							
in conserve	Examiner							AR	4 CCUDE	=MT			
	- +··	Examiner	Sequentially list conditions, if un, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a	i consequence of								
	and transi	xarr	Cause (Disease or linjury that initiated events resulting in death) Last	c. ATA	Consequence of):	FI	BRIL	LAT	101				
	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	calE	resulting in death) cast		consequence on.								
	icate l g phys is the			d									
89	certif ending use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3 🗆 Ectopic	prognancy			23d. Date of deli	very		
Bo	death he atte ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at		5 Other (s				Month	Day Year		
o.	at the d by tl etach		9 ☐ Unknown  Part II. Other significant conditions		ut not resulting in t	he underlying	cause given	in Part I.	23e Did tob	acco use contribute to	the cause of death?		
Division of Vital Records, P.O. Box 6876	res tha signer	Completed by	METASTA								obably 4 🗆 Unknown		
ord	requi been shoulk	lete							24a, Was an		opsy findings available		
ec	ne law e has age 2	dwo							autopsy perform	ed? prior to c	ompletion of cause of		
al F	an; Ti	Be C	25. Was case referred to medical examiner?	V	L more way		26. Place	of Death (Chec	1 Yes 2	No 1 Yes	2 No		
ΖĬ	hysici nis ce I direc	10	1 Yes 2 No	Hospital: 1 Inpatie	ent 2 🗆 ER/Outp		Other:	4 Nursing H	ome 5 Resider	ice 6 Other (Specia	5y)		
οι	ling P J. After ti funera	ate:	27. Manner of Death  1 ✓ Natural 5 ☐ Pending	28a. Date of injui (Month, Day		ıry	28c. Injury at work?		28d. Describe hov	/ injury occurred			
sior	Attend death ctor: /	Certificate:	2 ☐ Accident Investigat 3 ☐ Suicide 6 ☐ Could no	be 280 Place of Injur	ry - At home, farm	M street, facto		s 2 □ No	28f Location /Stre	eet and Number or Run	al Route Number		
Σį	al or A s after I Dire d in b		4  Homicide determine	building, etc		,,	,,		City or Town,		ar riodio ivarrisor,		
_	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  within 24 hours after death.  completed filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying P	nysicían: To the best of	my knowledge, de	ath occured a	at the time, da	ite and place, a	nd due to the cause	e(s) and manner as stat	ed. ause(s) and manner stated.		
	the H thin 24 the Fi	Me	only one) 3 Certifying N	urse Practioner: To the		lge, death occ	urred at the tin	ne, date and pla	ce, and due to the c	ause(s) and manner as s	stated.		
	คฐีคฐี เD		29b. Signature and title of certifier	MD			oc. License nu	mber 1096		d. Date signed (Month,			
	LO		0		eath (Item 23a) (Tur	D.i=0							
			NSHA GOLL	APALLI.	61210	10147	ROS	ERO	PAP RO	CKVILE	E, MOL0852		
	Stat Registra		30. Name and address of person who was a supplemental of the suppl	32. Registra	r's Signature	arked							

Physician/ Medical		. Decedent's Name (First, Middle, Last)  Hortense Agnes Jones	N	Reg ate of Death lonth ctober	Day Year 1, 2012 9:50 A		
Examiner		a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death		
Funeral	5	St. Mary 's Hospital           . Social Security Number         6. Sex         7. Age (In yrs. last birthd)		ate of Birth	St. Mary s  9. Birthplace (State or Fo		
Director		215-84-8863 1 □ M 2 🛣 F 98 Yrs		onth, Day, Ye 7/04/19			
show	1	Usual Residence of Decedent           0a. State         10b. County         10c. City, Town o		•	10d. Inside City L		
28a-f s ptified ptified		Maryland St. Mary's Mecha	nicsville		1 □ Yes 2		
3a or the n		0e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?		
"natural", or items 23a or 28a-f show sdical Examiner must be notified at bleed by Funeral Director	-	25280 Friendship School Road  1. Marital Status 12. Was Decedent Ever in U.S.	20659  3. Was Decedent of Hispanic Origin? (Specify Ye	es or No-	USA  14. Race - American Indian,		
amine		1 ☐ Never Married 2 ☐ Married	If Yes, specify Cuban, Mexican, Puerto Rican,  1 ☐ Yes 2 ▼ No Specify:	etc.)	Black, White, etc.		
iene. r than "natural" the Medical Exc Completed	-	3 🗷 Widowed 4 🗆 Divorced Year or Dates.	ecedent's Usual Occupation	1.0	Specify: White		
Medin	-	(Specify only highest grade completed) (G	ive kind of work done during most of working a. DO NOT use retired)	16	b. Kind of Business/Industry		
Hygiene other the ent, the Be Co		8 Ho	memaker		Own Home		
n and Mental Hygiene. Tis marked other than "reraumatic event, the Med To Be Comp		7. Father's Name (First, Middle, Last)  Clarence Wood	18. Mother's Name (First <b>Etta</b>	, Middle, Maid <b>Long</b>	den Surname)		
nd Me s mark umatic	$\vdash$		ailing Address (Street and Number or Rural Rout		ry or Town, State, Zip Code) 2065		
e trai			80 Friendship School I				
Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natun any injury or other traumatic event, the Medical once.  To Be Complete	2	1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery,	sposition (Name of Date crematory or other place)		c. Location - City or Town, State		
artmen ortant: njury		# 1	s Memorial Grd 10/05/2		Leonardtown, MD		
Impo any i	4	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Mattingley-Gardiner 41590 Fenwick St.,	Funer	al Home, P.A.		
Medical caminer	Cal Evaluille	Cal Evaluation	Siff or the tree of the tree o	resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):			
sician and burial-transit cal Examiner		cause. Enter Underlying Lause (Lisease or Injury that initiated events resulting in death) Last  C					
buri	11 2	C. Due to (or as a consequence of):  TEFEMALE:  3b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  C. Due to (or as a consequence of):  23c. If yes, outcome of pregnancy  1  Live Birth 2 Fetal death  4  Pregnant at time of death  9  Unknown	5 Other (specify)		23d. Date of delivery Month Day Year		
buri	II 2	C. Due to (or as a consequence of):  TFEMALE:  3b. Was decedent pregnant in the past 12 months?  1   Yes   2   No    C. Due to (or as a consequence of):  23c. If yes, outcome of pregnancy 1   Live Birth 2   Fetal death 4   Pregnant at time of death	5 Other (specify)				
buri	III 2	C. Due to (or as a consequence of):    C. Due to (or as a consequence of):   Due to (o	5 ☐ Other (specify)  ne underlying cause given in Part I.  2	1 Yes  4a. Was an autopsy performer Yes 2	Month Day Year  co use contribute to the cause of death  2 No 3 Probably 4 Probably 4 Prior to completion of caus death?		
buri	II   2	C. Due to (or as a consequence of):  TEMALE:  3b. Was decedent pregnant in the past 12 months?  1	5 ☐ Other (specify)  ne underlying cause given in Part I.  2  26. Place of Death (Check only	1 Yes  24a. Was an autopsy performe Yes 2 (	Month Day Year  co use contribute to the cause of death  2  No 3  Probably 4   24b. Were autopsy findings avail prior to completion of caus death?  1  Yes 2		
buri	II 2	C. Due to (or as a consequence of):    C. Due to (or as a consequence of):   Due to (o	5 Other (specify)  ne underlying cause given in Part I.  26. Place of Death (Check only varient 3 DOA Other: 4 Nursing Home 5 e of 28c. Injury at 28d. D	1  Yes  24a. Was an autopsy performer Yes 2   one)  Residence	Month Day Year  co use contribute to the cause of death  2 No 3 Probably 4 Probably 4 Prior to completion of caus death?		
buri	II 2	C. Due to (or as a consequence of):    C. Due to (or as a consequence of):   Due to (o	The underlying cause given in Part I.  26. Place of Death (Check only street, actory, office  28c. Injury at work?  M 1 Yes 2 No  28f. Life Street, factory, office  28f. Life Street, factory, office	1 Yes  44a. Was an autopsy performed Yes 2 fone)  Residence escribe how in	Month Day Year  co use contribute to the cause of death  2  No 3 Probably 4 Properties a second prior to completion of cause death?  1 Yes 2 No  e 6 Other (Specify)  njury occurred		
buri	III 22	C. Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or a	The underlying cause given in Part I.  26. Place of Death (Check only strient 3 DOA Other: 4 Nursing Home 5 of Y M 1 Yes 2 No Street, factory, office 285. Lt. C	1 Yes  14a. Was an autopsy performed Yes 2 (cone)  Residence escribe how in the performent of the performent of the performent of the performance	Month Day Year  co use contribute to the cause of death  2  No 3 Probably 4 24b. Were autopsy findings avail prior to completion of caus death?  1 Yes 2 No  e 6 Other (Specify)  njury occurred  t and Number or Rural Route Number, tate)		
buri	III 22	C. Due to (or as a consequence of):    Due to (or as a consequence of):	atient 3 DOA Other:  26. Place of Death (Check only of the color of th	1 Yes  44a. Was an autopsy performer Yes 2 one)  Residence rescribe how in the causeine, date and p	Month Day Year  co use contribute to the cause of death  2  No 3 Probably 4 Prior to completion of cause death?  1 Yes 2 No  1 Yes 2 No  24b. Were autopsy findings available of cause death?  1 Yes 2 No  25 No 3 Probably 4 No		
his certificate has been signed by the attending physician in director, page 2 should be detached for use as the burn director, page 2 should by Physician/Medical	III   2	C. Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or a	atient 3 DOA Other:  26. Place of Death (Check only of the color of th	1 Yes  24a. Was an autopsy performed Yes 2 One)  Residence Rescribe how in the Cause one, date and performed due to the cause one, date and performed Yes 2 One)	Month Day Year  co use contribute to the cause of death  2  No 3 Probably 4 Min  24b. Were autopsy findings avail prior to completion of caus death?  1 Yes 2 No  e 6 Other (Specify)  njury occurred  t and Number or Rural Route Number, tate)  (s) and manner as stated.  (s) and manner as stated.  Lace, and due to the cause(s) and manner ause(s) and manner as stated.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death September 30, 2012 Physician/ Larry Lloyd Jacobson 9:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4763 River Valley Way Prince Georges Bowie If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 5. Social Security Number 571-34-6494 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign May 9, 1928 California **Director** 84 1 **X** M 2 □ F or 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Westchester Bronxville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Manor Road 10708 USA permit. Page 1 and 2 should be filed within 72 hours after death volepartment of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: rr Yes, Give Year or Dates. 1950-52 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Shoe Industry Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Lloyd Jacobson Julia Marie Andersen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4763 River Valley Way Bowie, MD 20720 Robin Tarver/ Daughter 20a. Method of Disposition
1 ☐ Burial 2 🖪 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Huntt Crematory 10/03/2012 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician. 6 months Adenocarcinoma of the Stomach disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Senile Dementia 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Daughter's Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Spe-28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending injury Accident 1 Yes 2 No Investigation M filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours a Funeral I critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Cestifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a D22780 October 1, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

Peter Schissler MD

OCT 03 2012

7500 Greenway Center Drive Greenbelt, MD 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33746 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 30. Howard Melvin Jamison 2012 0625 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth \*Funeral Month, Day, Year 920 1 🛛 M 2 🗆 F Months 216-44-9036 91 Pennsylvania Director Nov. Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland Director Harford Bel Air Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code þ 10g. Citizen of What Country? items 23a Funeral U.S.A. 128 West Ring Factory Road, Apt. 1157 21014 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Year or Dates. 1 943-46 Black, White, etc. 6 1 Never Married 2 X Married Be Completed by 1 Yes 2 No Specify: Specify: "natural" 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. Mechanical Engineering Technician Aberdeen Proving Ground Elementary/Seconday (0-12) College (1-4 or 5+) Aberdeen, Maryland Twelve Years Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ၉ Howard Wesley Jamison Leta Mae Dawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 128 W. Ring Factory Rd., Apt. 1157, Bel Air, MD Department of Health ar Important: If item 27 is any injury or other trau A. Jean Calloway Jamison (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State West Chester, 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State cemetery, crematory or other place)
R.A.Ferris & Co., Inc. 10/04/12 4 ☐ Donation 5 ☐ Other (Specify) <u>Pennsylvania</u> Signature of Funeral Service Ligensee L'e le Mand Parte Frith & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ ORAC disease or condition Medical resulting in death) to (or as a consequence of): **Examiner** Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events ohysician and the burial-transit certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy nerformed? death? 1 ☐ Yes 2 X No Physician: Vital completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မ 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural To the Hospital or Attending 5 Pending work? Division 1 Yes 2 🗌 No within 24 hours after death, To the Funeral Director; A Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier +1 VK 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ACC 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 09/27 Physician/ Edith Kenton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medstar Montgomery Hospital Olney Montogmery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 219-28-1532 **Director** 85 05/25/1927 unknown permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🙀 No Maryland Silver Spring MD 10e. Street and Number 10g. Citizen of What Country? 15101 Interlachen Drive, Apt.311 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Employee Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, William Sadlack,MD Physician 8013 Rising Ridge Rd. Bethesda, Maryland 20817 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 10/04/2012 Silver Spring, Maryland 22. Name and Address of Facility Cole Funeral Services, P.A. 21. Signature of Funeral Service Licensee 4110 Aspen Hill Rd. #100. Rockville. MD 20853 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death 2 4 Hours Immediate Cause (Final Physician/ CARDZOMYOPATHY disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 🗷 No Month Dav Year 1 ☐ Yes 2 ⊭ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 🗌 Yes 2 💆 No 3 🗌 Probably 4 🗀 Unknown FAILURE TO THR IVE 24b. Were autopsy findings available prior to completion of cause of death? performed Yes 2 No 2 🗷 No Hospital or Attending Physician: Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 X No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 A Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) water. SEPT6MBER 28, 2012 023630 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANK J. MAYO, MO 16220 FREDERICK RIAD # ZIZ GASTHERSBURG, MARYLA-0 20677 31. Date filed (Month Day Year) 5 2012 Registrar's Signature

Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2012 Marion A. Kahles 10:00 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ellicott City Heartlands Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 269 10 1297 1 M 2 XF 94 May 25, 1918 Ohio 28e-f shov 10a. State in then "naturel", or items 23e or 28e-f sho the Wedcel Examiner it ust be notified at 10c. City, Town or Location with the Maryland 10d. Inside City Limits Directo MD 1 Yes 2 X No Ellicott City Howard 10e. Street and Number 10g. Citizen of What Country? Funeral 3004 N. Ridge Road H317 21043 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 Yes 2 No Specify. 3 X Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) <u>Tvoist</u> Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other treumetic ever ၉ Page 1 and 2 should be Charles Bill Julie Lettner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health ar Importent: If item 27 is eny Injury or other treu once. Jean Kahles/granddaughter 7703 Greenbrook Drive Greenbelt, MD 20770 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cremation Cntr of MD 10-5-2012 20c. Location - City or Town, State 1 Burial 2XI Cremation 3 Removal from State Hanover, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lir d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Exam Cause (Disease or injury that initiated events use es the burial-transl Due to (or as a consequence of): resulting in death) Last signed by the attending physiclen d be detached for use es the buria Physician/Medical The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Month Year Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Hospitel or Attending Physicien: The law require 24 hours after death. Funerel Director: After this certificate hes been si etely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy Yes 2 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 ဍ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Funer completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying furse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) アプイア ctoky UND 2917 30. Name and actives of person who completed cause of death (Item 23a) (Type, Print)

Registrar

20

State

31. Date filed (Month, Day, Year)

5 2012

Andy Lazris, MD 6334 Cedar Lane Suite 103 Columbia, MD 21044

egistrar's Signatu

		For		State of	of Marylar		artment of I		and Mo	ental Hy	giene	2012	33749
		State Registrar	Mina A Adadatia	Loot		Cer	tificate of l	Death_			Reg. No.	2012	
Physiciar	1/	1. Decedent's Name	_	,	7.1	T				2. Date of De Month	Day	Year	3. Time of Death
Medica Examine		Oscar  4a. Facility Name (if i			Kelsea,	JI.	4b. City, Town, o	r Location o	of Death	Octobe		2012 ounty of Death	3:40A <sup>M</sup>
)	Ž	Charlott	e Hall	Veterans	s Home			lotte		L		St. Ma	ary's
Funeral Director		5. Social Security Nu <b>002–22–0</b> 1	L <b>9</b> 7	6. Sex 1 <b>X</b> M 2 □ F	7. Age (In yrs. <b>82</b>	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da <b>08/11</b>		9. Birthp Coun <b>New T</b>	olace (State or Foreign try) lampshire
nd how	- 1	Usual Residence of I 10a. State	Decedent 10b. County		10c. Ci	ty, Town or Loc	eation						0d. Inside City Limits
larylar 3a-f sl ified	Director	Maryland	St.	Mary's		Lexing	ton Park	τ .					1 ☐ Yes 2 🌁 No
the N t or 28	₫	10e. Street and Num					10f. Zip Code				10g. Citize	n of What Cour	ntry?
h with	Funeral	19425	Point	Lookout l			20	)653			Ţ	JSA	
in in	≥∣	<ul><li>11. Marital Status</li><li>1 ☐ Never Marrie</li><li>3 ☐ Widowed 4</li></ul>		Armed Fo	2 No re	If	Vas Decedent of F Yes, specify Cuba	an, Mexican	, Puerto Ri	ify Yes or No- ican, etc.)		Race - Americ Black, White, o pecify:	
natur dical	Completed	(Sner		t's Education st grade completed			ent's Usual Occup		of working	_	16b. Kind	of Business Inc	dustry
hin 72 ne. than ' ie Me	E O	Elementary/Seco		College (1		life. Do	O NOT use retired)	)	. OF WORKING	J			_1
ed with Hygien other i	o l	12 17. Father's Name (F	irst Middle I	aetl			Inspec		or's Nome	(First, Middle,		quor Bo	ard
d be file Jental I arked c	ှိ မြ	Oscar	Geo	•	lsea, S	r.			eigh	Win		Gadwa	h
2 should the and the and the and the and the traume		19a. Informant's Nat <b>Elizabet</b>					g Address (Street						MD 20653
and Healt tem 2	ŀ	20a. Method of Disp		ea/Wile		Place of Dispo	sition (Name of		Da			ation - City or To	
Page nent of int: If iny or		1 X Burial 2 Donation		3 ☐ Removal from pecify)	State		natory or other pla Memorial	1	10/06	/2012	Leo	nardtow	m. MD
permit. Departr Importa any inju		21 Signature of Fun	eral Service L	icensee kar	dine	7 22	Name and Addre Matting 41590 Fe	ess of Facility	ardin	er Fun	eral	Home, P	.A.
Physician/		Immediate Cause (F	t failure. List o Final	complications that nly one cause on ea	ach line.	th. Do not ente	r the mode of dyir	ng, such as	cardiac or			1:	Approximate Interval Between Onset and Death
Medical Examiner		disease or condition resulting in death)	1	a. Due to	(or as a conseq		415he	Inc	$\sim$	De	wer.	MCI	
	iner	Sequentially list con if any, leading to im- cause. Enter Under	mediate	b. Due to	(or as a consec	juence of):							
ate be executed bhysician and the burial-transit	Examiner	Cause (Disease or i that initiated events	injury	C. Due to	(or as a consec	uonaa afi:							
burial	dical	resulting in death) L	ast	L	(or as a consec	querice oi).							
cate by phys	<u>ğ</u>			d									
The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-trans.		IF FEMALE: 23b. Was decedent   in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	1 Live	nant at time of	al death 3 🗌	Ectopic pregnan Other (specify)	су			23	d. Date of delive Month	ery Day Year
requires that the de been signed by the should be detached		Part II. Other signifi	cant conditio	ns contributing to d	leath but not re	sulting in the u	nderlying cause gi	iven in Part I	l. <b>5</b>	23e. Did t	obacco use	contribute to the	ne cause of death?
quires en sign	be	Coron	arcy	Heter	a Di	seas	61822	sent	ia l	1 🗆	Yes 2	No 3 🗆 Prol	bably 4 🗌 Unknown
has ber	Completed by	Hape	cter	31001	Brak	etes	Well	tus	1	24a. Was auto	psy	prior to co	psy findings available impletion of cause of
sician: The la certificate ha irector, page 2		Tich	emic	Card	10 my	1/ par	Di			1 🗆 Yes	2 No	death? 1 ☐ Yes	2 🗌 No
sician certifi rector	Be	25. Was case referre examiner? 1 ☐ Yes 2 【		Hospital:			Oth	lace of Deat	1			_	
y Phys er this eral dir	e: 10	27. Manner of Death		28a. Date		28b. Time of	t 3 □ DOA 28c. Injur	ry at		ne 5 L. Resid 3d. Describe h		Other (Specify ccurred	/)
ending Path.	ficat	1 Natural 2 Accident	5 Pendin	gation	th, Day, Year)	injury	M 1 L	k? Yes 2	No				
al or Attending Physician: s after death. Director: After this certific d in by the funeral director,	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could determ	ined 28e. Place	e of Injury - At hing, etc. (Specif		eet, factory, office		2	8f. Location (S City or Tov		lumber or Rural	l Route Number,
spital or ours afte reral Dire	edical C	29a. Certifier 1	Certifying	Physician: To the t	est of my know	vledge death of	occured at the time	e date and r	nlace and	due to the ca	use(s) and i	manner as state	ad.
Hos Pur Fur	Medi	(Check 2	Medical E		sis of examination	n and/or invest	igation, in my opini	ion, death oc	curred at t	he ti <mark>me, dat</mark> e a	and place, ar	nd due to the ca	use(s) and manner stated.
P P P P P P P P P P P P P P P P P P P		29b. Signature and t	itle of certifier	/	7/2//	. 0	29c. Licens	se number	~~		29d. Date	signed (Month,	Day, Year)
JA		20 No.	1 la	Well 1	vue	XV	YCI	9 1	SO	2	10	19/10	<u> </u>
MA		30. Name and addre	ess of person v	Wild completed cau	se or death (Iter	ii zoa) (Iype, F	hach	Halt	Hall	RAM	mdd	HoHall	MORKE
State	<u>ب</u>	31. Date filed (Month	n, Day, Year)	0 2010 32. F	Re astrar's Signa	ature	6-11		10011		6110	116 11641	4.10 0000
Registra	r ,		UCIO	2 2012	enva	p. 19	Take						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death Decedent's Name (First\_Middle\_Last. 2. Date of Death Physician/ 11:00 AM Catherine Kirtz October 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 23621 Abraham Drive <u>eonardtown</u> Mary's Social Security Number 7. Age (In vrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Months Days Hours (Month, Day, Year) 579-40-0440 Director 1 □ M 2 🗓 F Yrs 09/ 09/ 1920 Usual Residence of Decedent Canada i Hygiene. other then "neturel", or items 23e or 28e-f show vent, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location Director 10d. Inside City Limits St. Mary's Maryland 1 Yes 2 No Leonardtown 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 23621 Abraham Drive 20650 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Labor Statistician United States Government å 17. Father's Name (First, Middle, Last) should be file and Mental H 18. Mother's Name (First, Middle, Maiden Surname) Angus R. Mackay Mary MacLellan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 end 2 sh Depertment of Health ar Importent: If item 27 ls Mary Anne Kirtz item 2 Abraham Drive, Leonardtown, Maryland 20650 Baltimore. Importent: If iten eny Injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Maryland 4 ☐ Donation 5 ☐ Other (Specify) 10/07/2012 Brinsfield-Echols Charlotte 21. Signature of Feneral Service Cicensee

Edward N. Brinsfield, Jr. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. MO0052 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final NEUTE MYCCAROTA INTANETION Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ATHEROSCLERATIC CARDIO VASCULAR Y572 Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examin the ettending physicien end ched for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day g 🗌 Unknown g 🗌 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CONFESTIVE MEMIT Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No certificate 2 🗌 No 1 Yes To the Hospital or Attending Physicien: I within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10-5-12 D56096 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (2) RML Rajbinder S. Gill, M.D. 24035 Three Notch Road, Hollywood, MD 20636 31. Date filed (Month, Day, Year) State OCT 0 9 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2012 6:35 a.m Sachiko Kidd Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's St. Mary's Hospital Leonardtown Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Social Security Number **Funeral** 1 □ M 2 🗓 F Days 07/20/1930 **Director** 534-70-1989 82 Japan Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 💢 No Maryland St. Mary's Lexington Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral Japan 46520 Rosewood Drive 20653 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Midowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 0 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file.
Department of Health and Mental H
Important: If item 27 is marked ot
any injury or other traumatic even Haroichi Yaji Kane Yaji 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46520 Rosewood Drive, Lexington Park, MD Sally Hubbart/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🗌 Burial 2 🛣 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Cre 10/11/2012 Charlotte Hall, MD 21. Signato 1 Fu eral Servica Lorsee Kathleen Santivasci 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollvwood Road, Leonardtown, MD 20650 M00872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph, ician/ Ca chutes disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Cardiogenie Sequentially list conditions, Examiner Due to or as a consequence of cause. Enter Underlying Cause (Disease or iiniury 18000 sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical The law requires that the death certificate be ر ر ۱۰ کی tal Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death in the past 12 months?
1 Yes 2 No
9 Unknown Day Pregnant at time of death tor: After this certificate has been signed by the at the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 🗌 No М 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 ... Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif MN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year October 0 8 2012 5:35p.m<sup>M</sup> Medical <u>Elsie Viola Kachel</u> 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Lexington Park St. Mary's <u> Chesapeake Shores Nursing Center</u> If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthdav) 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** 1 □ M 2 🗓 F Months Days Min Director 201-05-8256 <u>Pennsylvania</u> Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location Examiner must be notified at 10a, State 10d. Inside City Limits Director 1 🗌 Yes 2 🏋 No Maryland St. Mary's Leonardtown 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 22680 Cedar Lane Court United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2X☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 ₩ Widowed 4 □ Divorced White Year or Dates 27 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) I Hygiene. College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Page 1 and 2 should be fill ment of Health and Mental tant: If item 27 is marked o မ Mary Elizabeth Keffer Charles Augustus Yerger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Horton/Daughter 22163 Erickson Court, Lexington Park, MD 20653 Barbara 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Department of H Important: If ite any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Trinity Mem. Gardens 10/12/2012 Waldorf, MD Nine of Funeral Service ticensee Minimus Santulaou Kathleen Santivasci M00872 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and I-transit Exami The law requires that the death certificate be executed Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year ned by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 No 1 Yes Yes 2 N or Attending Physician: ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Funeral Medical 29a. Certifier Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted f Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Within 2 29b. Signature and little of certifier ress of ps son who completed cause of death (Item 23a) (Type, Print) avaKoli Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 24, 2012 JOHN J. KILGARIFF 8:50 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Montgomery Examiner 4b. City, Town, or Location of Death Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral . Social Security Number 360-07-2761 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Director 1 X M 2 □ F 91 Illinois Dec. 23,1920 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Village Maryland Montgomery 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 19304 Frenchton Place 20886 12. Was Decedent Ever in U.S. Armed Forces?

1 \( \tilde{\text{L}} \) Yes 2 \( \tilde{\text{U}} \) Nq \( \frac{7}{42} \) If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Widowed 4 Divorced 11/21/46Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working T. life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Lawyer Justice Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cecilia Hughes John Joseph Kilgariff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19304 Frenchton Place Montgomery Village, MD 20886 Doreen M. Kilgariff (Spouse) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crem. Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 X Removal from State 26, Alexandria, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility DeVol Funeral Home E (M01116)10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory line, t. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ multi organo tallyre disease or condition resulting in death) Medical Due to (or as a consequence of): MO Examiner schemic borre Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 52p515 that initiated events Due to (or/as a consequence of): resulting in death) Last Physician/Medical pheumonia Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Day Year ate has been signed by the a page 2 should be detached 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 0057 right temur Completed I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 6tatus reduction interal fixation right femor 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate l fracture 1 ☐ Yes 2 ☐ No Yes 2 A No 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ft. 105t balance 1 Natural
2 Accident injury 5 Pending work? 1 🗌 Yes 2 🔼 No and fell backwards on bottom n 24 hours after death, le Funeral Director: Aft bletely filled in by the fu Investigation 09/18/2012 0900 AM 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined home 19304 Frenchton Pl. Galthersbus, Mary Ind Medical within 24 hound to the Funer completely file 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practitioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier မ 29c. License number 29d. Date signed (Month, Day, Year) 1+ erigallo 1323 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Drive, Ushakiran Yenisalland 9901 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 02 OCT Registrar

255

スノナイ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:00 A M Elizabeth October 2012 Medical JoAnn 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 130 Lakin Avenue Washington Boonsboro Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Age (In vrs. last birthday) **Funeral** Hours Min (Month, Day, Year) Director 217-28-6228 80 Yrs June 19. 1932 | Washington, MD Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 130 Lakin Avenue 21713 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 ☐ Yes 2 🗓 No If Yes, Give þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ould be filed within 72 ns. and Mental Hygiene.
is marked other than "r." avent, the Mer (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Clothing Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o James Raymond Reese E. Marie Foreman Reese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 130 Lakin Avenue Richard Lum Sr. / husband Boonsboro, MD 21713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State injury or Boonsboro Cemetery 10/10/2012 Boonsboro, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral pervice Lice see 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike Boonsboro, MD 21713 23a. Part / Enter the disease, or compile show, or heart failure. List only one Immediate Cause (Final hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death e on each line Physician/ disease or condition resulting in death) my ocardia hrs Medical Due to (or as a consequence Examiner pertension Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (o a consequence of): Huperlipidem Cause (Disease or injury for use as the burial-trans and that initiated events resulting in death) Last nding physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Vear Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes been sign 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 : autopsy performed Yes 2 death? 2 🗌 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) B B 2 No Other: 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10047234 08 M.D. 10

State Registrar

DHMH 17 Rev 06-2011

luansa

Ste 101

Hagerston

MO 21742

Hue

Pennsu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

13424

32. Registrar's Signature

Strauss

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:00 AM Janet, L, Leaf 9019 09 30 **Medical** 4a. Facility Name (if not institution, give street and number).
University & Maryland Hospital Examiner 4b. City, Town, or Location of Death 4c. County of Death NA Baltimore City 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 63 Director 212-52-8050 1 M 2 X 09/07/1949 Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 🛚 Yes 2 🗆 No MD Cecil Rising Sun 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 585 Pearl Street 21911 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married ☐ Yes Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed Specify: White 3 XWidowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Operations Officer Banking Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Oscar S. Eyet Dorothy Marie League 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samantha Leaf/ daughter 15th St. S.E., Apt. 205, Washington D.C. 20003 245 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 10/2/2012 cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rising Sun, MD Foard Funeral Home, P.A. 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 21. Signature of Funeral Service Lice 111 S. Queen St., Rising Sun, MD 21911 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heap ailure. List only one cause on each line. Approximate Interval Between shock, or hear Immediate Cause (Final disease or condition Onset and Death Ph\_sician/ invasive aspurgillous prumonia Medical resulting in death) **Examiner** immuno compromised Sequentially list conditions Physician/Medical Examine Due to (or as a consequence of) it any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events use as the burial-transi the attending physician and Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ page 2 should be detached for in the past 12 months? Month Day Yes 2 No 9 Unknown g Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by wng transplant, or, antitrypsin deficiency 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 🗌 Yes 2 🕒 Yes 2 within 24 hours after death.

To the Funeral Director: After this certific.
completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 ☑ Natural Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 E only one) 29c. License number 29d. Date signed (Month, Day, Year, 09/30/2013 M.D.P27357 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Negar Nonth, 28 S. Greene Baltimore MD 21201 Nadir

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 30,2012 Physician/ George Patrick Lang 1200 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Salisbury Salisbury Rehabilitation & Nursing Ctr. Wicomico Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Director 228-44-7832 1 🗶 M 2 🗆 F 75 05/01/1937 Virginia permit. Page 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other traumetic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Salisbury Maryland Wicomico 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21801 USA 1526 Sharen Drive, Apt. E Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Completed Specify. 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Tractor Company Clerk æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jewel Churn George Norman Lang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1526 Sharen Dr., Apt. E, Salisbury, MD 21801 Mary Lang/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/2/2012 Salisbury, MD Salisbury Crematory 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Licensee Commond CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Approximate Interval Between incl Immediate Cause (Final Onset and Death Physician/ Can disease or condition Medical resulting in death) as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examin Hospitel or Attending Physician: The law requires that the death certificate be executed 24 hours after death. igned by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate has ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vita! completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 200 Other: 1 ☐ Yes 은 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident М **Director:** 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined 24 hours a Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*The discretifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

\*\*The discretifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*The discretifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the I within 2 only one) Signatu ddress of person who completed cause of death (Item 23a) (Type, Print) ro dulla 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 Registrar

ang.

00

Q

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of	Maryland	/ Depa	artment of H	lealth ai	nd M	ental Hygi	ene		
			State Registrar			Cer	tificate of D	Death		Re	g. No. 2	112	33757
т	Physicia	n/	1. Decedent's Name (First, Middle	, Last)						2. Date of Death	Day A	Voor	3. Time of Death
	Medic	al	Barbara		Mills					Octobe	C"8,	2012	1145 M
	Examin	er	4a. Facility Name (if not institution		er)		4b. City, Town, or		Death		4c. County		
	Funeral		Meritus Medica  5. Social Security Number		. Age (In yrs. last	hirthday)	Hagers		4 Hrs.	8. Date of Birth	Was	hingt	on ace (State or Foreign
	Director		218-38-1263	1 M 2 🕱 F	70		Months Days		Min.	(Month, Day, Y		Countr	y)
	MC T		Usual Residence of Decedent							11/25/1	941		Virginia
	ryland -f sho	Director	10a. State 10b. County		10c. City, T							10	d. Inside City Limits
	ir 28a notif	Dire	Maryland Wash:	ington	наде	rstow	7n 10f. Zip Code			1.40	g. Citizen of V		1 X Yes 2 □ No
	vith th		619 George St	reet			21740			10		vnat Count	ry ?
	tems	Funeral	11. Marital Status	12. Was Decede		13. V	Vas Decedent of His	spanic Origin	n? (Spec	ify Yes or No-		e - America	n Indian,
92	fter d , or i	by	1 Never Married 2 Married	ried Armed Force 1 Yes 2 If Yes, Give			f Yes, specify Cubar  Yes 2 🛭 No		Puerto R	ican, etc.)		k, White, et	
ĕ	within 72 hours after death with the Maryland jiene. sr than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Completed	3 X Widowed 4 ☐ Divorced	Year or Date		l					Specify:	Whi	te
5	72 hc n "na Aedic	nple	(Specify only highe	nt's Education est grade completed)		(Give I	lent's Usual Occupa kind of work done di O NOT use retired)	ation <i>uring m</i> ost o	of working	g 1	6b. Kind of Bu	ısiness/Ind	ustry
212	I within 72 ygiene. her than ' t, the Me		Elementary/Secondary (0-12)	College (1-4	or 5+)		emaker				Dome	stic	
pu	filed wit al Hygie d other vent, th	Be	17. Father's Name (First, Middle, L	.ast)	•			18. Mother's	s Name	(First, Middle, Ma	iden Surname	)	
ylaı	uld be file Mental narked o	입	David Hudghel	Morningsta	ar			Dais	зу Ве	ell John	son		
Maryland 21215-0036	shou and is n	'n	19a. informant's Name/Relationsh				ng Address (Street a				•		
	1 and 2 soft Health item 27 other tra		Tracy Gelwicks 20a. Method of Disposition	/ Daughter			Linganor	e Ave.					
Baltimore,	permit. Page 1 a Department of the Important: If ite any injury or of once.		1 🗓 Burial 2 🗌 Cremation		tate cem	etery, cren	sition (Name of natory or other place				0c. Location -	•	
Ē	nit. Pa antme ortan injuny	I (	4 Donation 5 Other (S		Rest		en Cemete  Name and Address						Maryland
ñ	Depar Impor any ir	33	> S. Mark.	Suns			601 Penns						
	Physician Medical Examiner	ər	23a. Part 1. Enter the disease, or shock, or heart failure. List of the shock of th	a. Due to (or	as a consequence in the	ce of):	S/ACC		ardiac or	respiratory arrest	,		Approximate Interval Between Onset and Death
	ed nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequent		10 PE	<b>-</b> - 11					ļ
	xecut n and ial-tra	Еха	that initiated events resulting in death) Last	c. Due to (or									
09	sate be executed physician and the burial-transit	dical		d	CHON	(C	RESPIR	Moth	-7	FATU	NE		
876	tificat ng ph		IF FEMALE:	T									
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transical properties.		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		rth 2 🗌 Fetal de int at time of deal	eath 3 🗌	Ectopic pregnancy Other (specify)	/			23d. Dat Moi	e of deliver nth [	y Day Year
P.O.	that t ned b e deta	by P	Part II. Other significant condition		th but not resulting	ng in the u	nderlying cause give	en in Part I.		23e. Did toba	cco use contr	ibute to the	cause of death?
ds,	quires en sig ould b	ted	DECUMT	15 Mi	5M					1 🗆 Yes	2 🗆 No	3 Proba	bly 4 dnknown
cor	has be te 2 sh	nple	ANE	inia						24a. Was an autopsy	24b. V	Vere autops rior to com	y findings available pletion of cause of
Re	: The cate h									performe 1 Yes 2		leath?	□ No
ita	sician: The certificate irector, pag	œ	25. Was case referred to medical examiner?	Hospital:	,		1	ce of Death	(Check c	only one)			
<b>)</b>	Phys	5: 70	1 Yes 2 No 27. Manner of Death	1 🗹 In 28a, Date of	patient 2 ER	Outpatien  b. Time of	t 3 DOA Other	4 ∐ Nurs		e 5 Resident			
Division of Vital Records,	tth. : After e funel	Certificate:	1 Natural 5 Pendin 2 Accident Investig	g (Month,	Day, Year)	injury	work?	on Yes 2. □ N	- 1	d. Describe flow	injury occurre	:u	
isio	l or Attener deat after deat Director:	ertifi	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	Injury - At home	, farm, stre	et, factory, office		28	Bf. Location (Stree		r or Rural F	oute Number,
<u>S</u>	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page				, etc. (Specify)					City or Town, \$			
	Hospita 24 hours Funeral stely filled	Medical	(Check 2 \( \subseteq Medical E	Physician: To the bes xaminer: On the basis	of examination an	d/or invest	igation, in my opinior	n, death occu	ırred at th	ne time, date and i	place, and due	to the caus	e(s) and manner stated.
	To the within 2 To the Comple		only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practitioner: T	o the best of my k	nowledge,	death occurred at th	e time, date a	and place	e, and due to the o	cause(s) and m	anner as sta	ited.
	78		· An	ラ				6200	6	10/	19/12	-	,,
	A		30. Name and address of person v	who completed cause	of death (Item 23	a) (Type, P		5 200		11.9/	1, -		
			prio Ay	7A160		m	1111	6 M	501	con c	mpi	1 R	D HAYGYD
	Stat	е	31. Date filed (Month, Day, Year)	2012 32. Feg	istrar's Signature	6	alle						n

DHMH 17 Rev 06-2011

### 12-07550 Robert Jay Miller

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.				
	State of Maryland / Department of Health and Mental Hygiene				
State	Certificate of Death Reg. No.	2	n	-	2
adant's	Name (First Middle Leet)	Sympe	A.	12	Time

Physici		1- For State Registrar	Certific	cate of D	eath		Reg. No.	20	12 337
cal Exam		Decedent's Name (First, Middle,Last)	-			2. Date of Month	Death Day or 5, 201:	Year	3. Time of Death 1538 hrs
Cai Exaili	mei	Robert Jay Mil  4a. Facility Name (if not institution, give str		4b (	City, Town, or Location		r 5, 201.	. County of Death	
		819 South Potomac Street	,		agerstown			Vashington	
Funeral		Social Security Number     6. Sex	7. Age (In yrs. last bi	oirthday) If	Under 1 Year If Und		f Birth(MM/	(DD/YYYY) 9. Bir	
Director			2□F 50	Yrs.	Months Days Hours	Min. May	14,19	62 Foreig	-Mayryland
*us		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	vn or Location					10d. Inside City Limits
<b>A</b>	_	Maryland Washing	iton	Hage	erstown				1 Yes 2 No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number			f. Zip Code		10g. Citi	zen of What Cou	ntry?
the M n or 2 tiffed	Ö	819 South Potomac	Street		21740			USA	A
72 hours after death with the Maryland in "natural", or items 23a or 28a-f sho sal Examiner must be notified at once,	eral		2. Was Decedent Ever in U.S. Armed Forces?		cedent of Hispanic Ori			14. Race - Ameri White, etc.	ican Indian, Black,
or ite	Fune		Yes 2 No					_	71. ' L
s after	by	3 Widowed 4 Divorced If Y or 15. Decedent's Education (Specify only h	Dates:		s 2 X No specify:		1165		White
"natu Exar	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)		of working life. DO NOT				Industry
hin 7, te. than edical	lple	9		Truc	k Driver		I	'ransport	cation
filed within I Hygiene. ed other tha	Comple	17. Father's Name (First, Middle, Last)			18.Mother	r's Name (First, Midd	le, Maiden	Surname)	
be fil ntal H rked	Be	Robert Lee Mille				ice Fay			
permit. Pages I and 2 should be filed within 72 hours a Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "matura Important: If item 27 is marked other than "matura injury or other traumatic event, the Medical Examin	입	19a. Informant's Name/Relationship (Type George K. Miller -			dress (Street and Nur Clear Sprin				
nd 2 saith a		20a. Method of Disposition			(Name of cemetery,	Date		Location - City or	
ges l a of He If it		1 Burial 2 X Cremation 3		natory or other p	lace)				
t. Pag tment rtant;		4 Donetion 5 Other Specify:	Hager	stown C	rematory and Address of Facility				Maryland
permi Depar Impo injury		21. Signature of Funeral So vice Licensia			S. Conococ	ODDOLITO		ral Home	
ysician		23a. Part I. Enter the disease, or complicat	tions that caused the death. Do	not enter the m	ode of dying, such as o	cardiac or respiratory	arrest, sho	ock, or heart	Approximate Interval
Medical		failure. List only one cause on each I Immediate Cause (Final disease a. Co	<sub>ine.</sub> ocaine Intoxica	tion					Between Onset and Death
kaminer			to (or as a consequence of):	LION					
	اےا	Sequentially list conditions, b							
	Examine	cause. Enter Underlying Cause	e to (or as a consequence of):						
		(Disease or injury that initiated	to (or as a consequence of):						
	×	events resulting in death) Last Due							
ecuted and transit		d.		-f per	me (1932 10	1-22-12 sn		<u></u>	
be execute sician and ourial - trans	edical	d.  X UNPENDED A	MENDED 23a, 27, 28a		me,g932 10	)-22-12 su			
ate be ex ohysician oe burial	Medical	d.  X UNPENDED A  IF FEMALE: 23b. Was decedent pregnant in the	MENDED 23a, 27, 28a	су				d. Date of delivery	
ate be ex ohysician oe burial	Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	MENDED 23a, 27, 28a	cy 2 Fetal d		)—22—12 str			y Day Year
ate be ex ohysician oe burial	Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	MENDED 23a, 27, 28a  3c. If yes, outcome of pregnance    Live birth    Pregnant at time of death    Unknown	cy 2 Fetal d 5 Other	eath 3 Ectopio	c pregnancy	230	Month E	Day Year
ate be ex ohysician oe burial	Physician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	MENDED 23a, 27, 28a 23c. If yes, outcome of pregnance 1 Live birth 4 Pregnant at time of death	cy 2 Fetal d 5 Other	eath 3 Ectopio	c pregnancy	23d	Month E	Day Year the cause of death?
ate be ex ohysician oe burial	by Physician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	MENDED 23a, 27, 28a  3c. If yes, outcome of pregnance    Live birth    Pregnant at time of death    Unknown	cy 2 Fetal d 5 Other	eath 3 Ectopio	c pregnancy	id tobacco Yes 2	Month E	the cause of death?
ate be ex ohysician oe burial	by Physician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	MENDED 23a, 27, 28a  3c. If yes, outcome of pregnance    Live birth    Pregnant at time of death    Unknown	cy 2 Fetal d 5 Other	eath 3 Ectopio	c pregnancy  art I. 23e. D  24a. V  a	230 id tobacco Yes 2 //as an utopsy	wse contribute to  No 3 Prot  24b. Were au prior to co	Day Year the cause of death?
ate be ex ohysician oe burial	by Physician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	MENDED 23a, 27, 28a  3c. If yes, outcome of pregnance    Live birth    Pregnant at time of death    Unknown	cy 2 Fetal d 5 Other	eath 3 Ectopio	c pregnancy  art I. 23e. D  24a. V  a	id tobacco Yes 2	use contribute to  No 3 Prot  24b. Were au prior to co death?	the cause of death?  pably 4  Unknown  utopsy findings available completion of cause of
ate be ex ohysician oe burial	Completed by Physician/Medical	d.  X UNPENDED  A  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical	MENDED 23a , 27 , 28a 23c. If yes, outcome of pregnancy    Live birth    Pregnant at time of death    Unknown  Intributing to death but not resulti	2 Fetal d 5 Other	eath 3 Ectopion (Specify)  Hying cause given in Page 26. Place of Death	c pregnancy  art I. 23e. E  1 24a. V  1 ✓ Y  (Check only one)	23d dobacco Yes 2 // // // // // // // // // // // // /	wse contribute to  No 3 Prot  24b. Were au prior to o death? 1 Ye	the cause of death?  pably 4  Unknown  utopsy findings available completion of cause of
ritions. The law requires that the death certificate be ex- is certificate has been signed by the attending physician director, page 2 should be detached for use as the burial	by Physician/Medical	d.  X UNPENDED  A  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions conditions  25. Was case referred to medical examiner?  1 Yes 2 No	MENDED 23a , 27 , 28a  23c. If yes, outcome of pregnance  1 Live birth  4 Pregnant at time of death  9 Unknown  ntributing to death but not resulti	2 Fetal d 5 Other  Ting in the unde	eath 3 Ectopii (Specify)  rlying cause given in Pa  26. Place of Death DOA Other	c pregnancy  art I. 23e. E  24a. V  a  1 ✓ Y  (Check only one)  Nursing Home 5	23d did tobacco Yes 2 //as an utopsy erformed? es 2 N Reside	use contribute to  No 3 Prot  24b. Were au prior to c death? 1 Ye	the cause of death?  pably 4  Unknown  utopsy findings available completion of cause of
ing Physicians: The law requires that the death certificate be ex After this certificate has been signed by the attending physician tuneral director, page 2 should be detached for use as the burial	To Be Completed by Physician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions collections  25. Was case referred to medical examiner?  1 ✓ Yes 2 No  27. Manner of Death	MENDED 23a , 27 , 28a  23c. If yes, outcome of pregnance    Live birth   Pregnant at time of death   Unknown   Unknown   Unknown   Litalian	2 Fetal d 5 Other  ing in the unde	26. Place of Death  DOA  Other  28c. Injury at Work	c pregnancy  art I. 23e. D  24a. V  a  1 ✓ Y  (Check only one)  Nursing Home 5	23d  d tobacco  Yes 2  /as an  utopsy erformed?  es 2  N  Reside	wse contribute to  No 3 Prot  24b. Were au prior to o death? 1 Ye	the cause of death?  pably 4  Unknown  utopsy findings available completion of cause of
ing Physician: The law requires that the death certificate be ex After this certificate has been signed by the attending physician tuneral director, page 2 should be detached for use as the burial	To Be Completed by Physician/Medical	d.  X UNPENDED  A  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions conditions  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending Investigation	MENDED 23a, 27, 28a  23c. If yes, outcome of pregnance    Live birth   Pregnant at time of death   Unknown   Intributing to death but not resulting    Dital:   Inpatient   2   ER/0    28a. Date of Injury (Month, Day, Year)   fd 10-5-12   fd	2 Fetal d 5 Other  Coutpatient 3 Coutpatient 3 Coutpatient 3 Coutpatient 3	26. Place of Death DOA Other Yes 2 X	c pregnancy  23e. D  24a. V  a  1 ✓ Y  (Check only one)  Nursing Home 5  X? 28d. Descr	23d did tobacco Yes 2 /as an utopsy erformed? Reside Reside how inju	Month  use contribute to  No 3 Prot  24b. Were au prior to c death? 1 ▼ Ye  ence 6 ▼ Other  ury occurred	the cause of death?  pably 4 V Unknown  utopsy findings available completion of cause of  es 2 No
ing Physicians: The law requires that the death certificate be ex After this certificate has been signed by the attending physician tuneral director, page 2 should be detached for use as the burial	To Be Completed by Physician/Medical	d.  X UNPENDED  A  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  Columbia  25 Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending Investigation  3 Suicide 6 K Could not be determined	MENDED 23a , 27 , 28a  23c. If yes, outcome of pregnance of the pregnant at time of death pregna	2 Fetal d 5 Other  Outpatient 3 Coutpatient 3 Coutpatient 4 3:00 p farm, street, farm, street, farm	26. Place of Death DOA Other 28c. Injury at Work The State of Death Yes 2 Cotory, office building, e	c pregnancy  art I.  23e. D  24a. V  a  1 ✓ Y  (Check only one)  Nursing Home 5  X? 28d. Descr  unkno  tc.  28f. Locatie or Tow	23d  did tobacco  Yes 2  /as an  utopsy erformed?  es 2  N  Reside  wn  (Street a n, State)	use contribute to  No 3 Prot  24b. Were au prior to death?  1 V Yearnoe 6 Other  Other or Rund Number or Rund Number or Rund 819 Sout1	the cause of death?  pably 4  Unknown  utopsy findings available completion of cause of
ing Physician: The law requires that the death certificate be ex After this certificate has been signed by the attending physician tuneral director, page 2 should be detacted for use as the burial	Certification: To Be Completed by Physician/Medical	d.  X UNPENDED  A  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions conditions  25. Was case referred to medical examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 X Could not be determined  29a. Certifier Check only 1 Certifying Physician:	MENDED 23a , 27 , 28a  23c. If yes, outcome of pregnance of the live birth of the li	Power of the control	26. Place of Death DOA Other 2 28c. Injury at Work 1 Yes 2 Xectory, office building, et	c pregnancy  art I. 23e. E  1 24a. V  art I. 24a. V  (Check only one)  Nursing Home 5  R? 28d. Descr  No unkno  tc. 28f. Location or Tow  Hage: ace, and due to the	23d did tobacco Yes 2 /as an atopsy erformed? Reside be how injute on (Street a n, State) crstown cause(s) an	use contribute to  No 3 Prot  24b. Were au prior to c death? 1 V Ye  ance 6 Other ury occurred  and Number or Ru 819 Sout1	the cause of death?  pably 4  Unknown  utopsy findings available completion of cause of  es 2  No  r. Scene  ural Route Number, City  h Potomac St  ed.
ing Physician: The law requires that the death certificate be ex After this certificate has been signed by the attending physician tuneral director, page 2 should be detacted for use as the burial	Certification: To Be Completed by Physician/Medical	d.    X UNPENDED	MENDED 23a , 27 , 28a  23c. If yes, outcome of pregnance of Live birth    Pregnant at time of death   Unknown	Power of the control	26. Place of Death DOA Other 2 28c. Injury at Work 1 Yes 2 Xectory, office building, et	c pregnancy  art I. 23e. E  1 24a. V  art I. 24a. V  (Check only one)  Nursing Home 5  R? 28d. Descr  No unkno  tc. 28f. Location or Tow  Hage: ace, and due to the	23d did tobacco Yes 2 /as an atopsy erformed? Reside be how injute on (Street a n, State) crstown cause(s) an	use contribute to  No 3 Prot  24b. Were au prior to c death? 1 V Ye  ance 6 Other ury occurred  and Number or Ru 819 Sout1	the cause of death?  pably 4  Unknown  utopsy findings available completion of cause of  es 2  No  r. Scene  ural Route Number, City  h Potomac St  ed.
ricians. The law requires that the death certificate be existentificate has been signed by the attending physician director, page 2 should be detached for use as the burial	To Be Completed by Physician/Medical	d.    X UNPENDED	MENDED 23a , 27 , 28a  23c. If yes, outcome of pregnance of the live birth of the li	Power of the control	26. Place of Death DOA Other 2 28c. Injury at Work 1 Yes 2 Xectory, office building, et	c pregnancy  23e. D  24a. V  24a. V  (Check only one)  Nursing Home 5  (? 28d. Descr  No unkno  tc. 28f. Location  or Tow  Hage  ace, and due to the courred at the time, of	23d  /as an  /at an  /	use contribute to  No 3 Prot  24b. Were au prior to c death? 1 V Ye  ance 6 Other ury occurred  and Number or Ru 819 Sout1	the cause of death?  pably 4  Unknown  utopsy findings available completion of cause of  es 2  No  r: Scene  ural Route Number, City  h Potomac St  ee cause(s)
ing Physician: The law requires that the death certificate be ex After this certificate has been signed by the attending physician tuneral director, page 2 should be detacted for use as the burial	Certification: To Be Completed by Physician/Medical	d.  X UNPENDED  A  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions conditions  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending Investigation  3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Physician: One)  2 Medical Examiner: On an	MENDED 23a , 27 , 28a  23c. If yes, outcome of pregnance of Live birth    Pregnant at time of death   Unknown	Power of the control	26. Place of Death DOA Other 28c. Injury at Work 1 Yes 2 Xectory, office building, earth the time, date and plain my opinion, death oc	c pregnancy  23e. D  24a. V  24a. V  (Check only one)  Nursing Home 5  (? 28d. Descr  No unkno  tc. 28f. Location  or Tow  Hage  ace, and due to the courred at the time, of	23d did tobacco Yes 2 //as an utopsy erformed? Reside ible how injuit wn on (Street a ann, State) cause(s) an late and plate a	use contribute to  No 3 Prot  24b. Were au prior to c death? 1 Ye  ance 6 Other  oury occurred  and Number or Ru 819 Sout1  d manner as state ace, and due to the	the cause of death?  pably 4  Unknown  utopsy findings available completion of cause of  es 2  No  r. Scene  ural Route Number, City  h Potomac St  ed.  ee cause(s)  nth, Day, Year)
To the Hospital or Attending Physician: The law requires that the death certificate be extending thous after death.  To the Fuoeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Certification: To Be Completed by Physician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending Investigation  3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Physician: one)  29b. Signature and title of certifier  30. Name and address of person who com	MENDED 23a, 27, 28a  23c. If yes, outcome of pregnance of the live birth of the live	2 Fetal d 5 Other Coutpatient 3 to Time of Injury d 3:00 p farm, street, fa d at ho death occurred or investigation,	26. Place of Death  DOA Other  28c. Injury at Work  1 Yes 2 X  ctory, office building, et at the time, date and plain my opinion, death of O.C. M.E.	c pregnancy  art I.  23e. D  24a. V  ap  1 ✓ Y  (Check only one)  Nursing Home 5  R?  28d. Descr  No unkno  tc. 28f. Location or Tow  Hage: ace, and due to the courred at the time, of	23d	use contribute to  No 3 Prot  24b. Were au prior to c death? 1 V Ye  ence 6 Other  on Number or Ru  819 Sout1  and Number as state ace, and due to the  Date signed (Mo.	the cause of death?  pably 4  Unknown  utopsy findings available completion of cause of  es 2  No  r. Scene  ural Route Number, City  h Potomac St  ed.  ee cause(s)  nth, Day, Year)
ing Physician: The law requires that the death certificate be ex After this certificate has been signed by the attending physician tuneral director, page 2 should be detached for use as the burial	Certification: To Be Completed by Physician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending Investigation  3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Physician: one)  29b. Signature and title of certifier  30. Name and address of person who com	MENDED 23a, 27, 28a  23c. If yes, outcome of pregnance of the live birth of the live	2 Fetal d 5 Other Coutpatient 3 to Time of Injury d 3:00 p farm, street, fa d at ho death occurred or investigation,	26. Place of Death  DOA Other  28c. Injury at Work  1 Yes 2 X  ctory, office building, et at the time, date and plain my opinion, death of O.C. M.E.	c pregnancy  art I.  23e. D  24a. V  ap  1 ✓ Y  (Check only one)  Nursing Home 5  R?  28d. Descr  No unkno  tc. 28f. Location or Tow  Hage: ace, and due to the courred at the time, of	23d	use contribute to  No 3 Prot  24b. Were au prior to c death? 1 V Ye  ence 6 Other  on Number or Ru  819 Sout1  and Number as state ace, and due to the  Date signed (Mo.	the cause of death?  pably 4  Unknown  utopsy findings available completion of cause of  es 2  No  r. Scene  ural Route Number, City  h Potomac St  ed.  ee cause(s)  nth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day 29 3. Time of Death Month Physician/ ам Amilcar Marrero September 2012 Medical 4c. County of Death 4a. Facility Name (if not iristitution, give street and number) 4b. City, Town, or Location of Death **Examiner** Holy Cross Hospital Silver Spring <u>Montgomery</u> Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min Months Davs Hours 059-46-9892 Director 1 🛣 M 2 🗆 F 58Yrs. Feb. 22, 1954 Illinois Usual Residence of Decedent 10d. Inside City Limits 28a-f shov at 10a. State 10h. County 10c. City. Town or Location Director Examiner must be notified 1 Yes 2 No MD Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 23a 3804 Kelsey Street 20906 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. o 1 Yes 2 X No 1 Never Married 2 Married þ 2 should be filed within 72 hours after thand Mental Hygiene.
27 is marked other than "natural", or traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 Nes 2 No Specify: Puerto Rican Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) US Treasury Dept Law Enforcement Officer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Julio Cesar Marrero Page 1 and 2 should be Cecilia Gonzalez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Soledad N. Farfan Marrero/Wife of Health 3804 Kelsey Street, Silver Spring, MD 20906 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Metropolitan
Crematory Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 2012 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring MD 20001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner b Diabetes Mellitus-Type I Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury ansit State the Hospital or Attending Physician; The law requires that the death certificate be executed Hypertension and that initiated events Due to (or as a consequence of): resulting in death) Last use as the burial physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atter in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 LyUnknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 X No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 1 X Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA ည 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1 🔀 Natural 5 Pending Investigation Could not be ☐ Accident 6 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 

State Registrar (Check

29b. Signature and title of certifier

Daniel K. Sherk, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number D67355 29d. Date signed (Month, Day, Year)

Sept. 29, 2012

Admend item#	1-Cecil Co Health Dept Please Type or Pri	nt in Black In	delible Inl	k. Ensure A	II Copies	s Are ⊾egible	
		aryland / Depa	irtment of H	lealth and M			0 00760
	1. Decedent's Name (First, Middle, Last)  Mawyer	Cer	tificate of L		2. Date of Dea		3. Time of Death
Physician/ Medical	Dorothy <del>Noyer</del>	-	-		ctober	2, Day 2012 Year	11:00 AM
Examiner	4a. Facility Name (if not institution, give street and number)  Laurelwood Nursing Center		4b. City, Town, or Elkton	Location of Death		4c. County of Dea	ath
Funeral Director		e (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt Septh, Da		rthplace (State or Foreign
	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	ection				10d. Inside City Limits
Marylan Ba-f sh tiffied a	Maryland Cecil	E1kton	ation				1 X Yes 2 No
leath with the Maryland tems 23a or 28a-f she er must be notified at Funeral Director	10e. Street and Number 100 Laurel Drive	-	10f. Zip Code 21921			10g. Citizen of What C	*
- I = -	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent 8 Armed Forces 2 1 Yes 2	No		spanic Origin? (Spec n, Mexican, Puerto F	cify Yes or No- Rican, etc.)		erican Indian,
Maryland 21215-0036 12 should be filed within 72 hours after the and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam. To Be Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5	(Give F	O NOT use retired)	ation during most of workir	ng	16b. Kind of Business	,
land Z	17. Father's Name (First, Middle, Last) George Washington Dunsmor	:e		18. Mother's Name	, , ,		
Mary, Mary	19a. Informant's Name/Relationship (Type, Print) Henry Kirk		g Address (Street a			r, City or Town, State, Z amento, CA	
Baltimore, permit. Page 1 and Department of Hee mportant: If item my injury or othe pince.	20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disponsion Communication Rose Ban	natory or other place			20c. Location - City of Rising Sun	· ·
Baltimo permit. Page Department c Important: if important: if any injury or	21. Signatur statum and Sarvice linensee					eral Home, East, MD	P.A. 21901
	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause or each line Immediate Cause (Final	d the death. Do not ente e.			r respiratory an	rest,	Approximate Interval Between Onset and Death
Medical Examiner	disease or condition	a consequence of):	Heart D	isease			Unknower
niner	cause. Enter Underlying	a consequence of):					
be execute sician and burial-transit	Cause (Disease or linjury that initiated events resulting in death) Last c. Due to (or as	a consequence of):					
Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate be exhin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician mpleted filled in by the funeral director, page 2 should be detached for use as the burnamed of the funeral director, page 2 should be detached for use as the burnamed for the funeral director.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 4   Pregnant 2 9   Unknown	2 Fetal death 3	Ectopic pregnand Other (specify)	ey .		23d. Date of d Month	elivery Day Year
S, P.O ires that the signed by d be detailed by PI	Part II. Other significant conditions contributing to death to Chronic Obstructive K	out not resulting in the u	nderlying cause given	ven in Part I.		obacco use contribute	to the cause of death?
Records. The law require bate has been sipage 2 should					24a. Was auto perfo	psy prior to death?	utopsy findings available completion of cause of
ital Fician: Tician: Tician: Tician: Tician: Tician: Berton, perception, perce	25. Was case referred to medical examiner?  1  Yes 2  No  Hospital:		LOth	ace of Death (Check	only one)		
of Ving Physic ter this coneral direction	1 ☐ Yes 2 ☐ NO 1 ☐ Inpat  27. Manner of Death 28a. Date of inju	ient 2 ER/Outpatier ury 28b. Time of injury	nt 3 □ DOA	4 Nursing Hory at		dence 6 Other (Spenow injury occurred	ecify)
Division of Vital Reco To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has to completed filled in by the funeral director, page 2 s Medical Certificate: To Be Compl	2 \subseteq Accident Investigation	ury - At home, farm, stre	M 1 🗆	Yes 2 □ No		Street and Number or R	ural Route Number,
Div spital or hours aft neral Dir I filled in	29a, Certifier 1 Certifying Physician: To the best of	f my knowledge, death o	occured at the time	, date and place, and	City or Tov	use(s) and manner as s	tated.
the Hospita thin 24 hours the Euneral mpleted filled	(Check 2 Medical Examiner: On the basis of e only one) 3 Certifying Nurse Practioner: To the 29b. Signature and title of certifier	examination and/or invest	tigation, in my opinio	on, death occurred at time, date and place	the time, date a	and place, and due to the e cause(s) and manner a	e cause(s) and manner stated. as stated.
5 2 5 8	Jackdev-S			23322		29d. Date signed (Mon	. 20/2 .
.3	30. Name and address of person who completed cause of C. S. SACHDEV MD. 18	death (Item 23a) (Type, F	Print)	Elkton	Mn2		
State Registrar		rar's Signature	, 0			· / ===-/	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		for State		State of Ma	aryland		artment of H rtificate of D		and M	ental Hy		0.0	10	2.2	761
		Registrar  1. Decedent's Name (	First, Middle, Last	r)			tillcate of L	, catri		2. Date of De	Reg. No eath	<u>-                                    </u>	14	3. Time of	Death
Physic Med		Mary		Mille	V	- 11				Septemb	Da		ear OD	3:00	MAC
Exam	iner	4a. Facility Name (if no		street and number)			4b. City, Town, or					. County of			
Funera		5. Social Security Num	nber 6. Se	X 7. Age	In yrs. last	birthday)	If Under 1 Year	If Under		8. Date of Bir	th	al tim	Birthol	ace (State or	r Foreign
Directo		163-42-9	9083	JM 2 13€F 6	3	Yrs.	Months Days	Hours	Min.	(Month, De	ay, Year)		Countr PA		· orongin
how at	٦_	Usual Residence of I	Decedent 0b. County			Town or Lo	cation		<u> </u>	0-2-1	747			d. Inside Cit	by Limits
faryla Ba-f s tified	ecto	MD E	Baltimo:	re			Mill						1.0	1 🗆 Yes	
the Na or 2	ā	10e. Street and Numb					10f. Zip Code				10g. Cit	tizen of Wha	at Counti	ry?	
th with ms 23. must	Funeral Director		Leseda	Court #		· · · · · · · · · · · · · · · · · · ·	21244				USA				
<b>DEJILIMOTE, IMARY/IBING 2.12.13-UUJ30</b> permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	11. Marital Status  1  Never Married	d 2 ☐ Married	12. Was Decedent E Armed Forces? 1 Yes 2 St			Was Decedent of His If Yes, specify Cubar	n, Mexicar	i, Puerto R				White, et	tc.	
5-0036 ! hours after "natural", o		3 XWidowed 4		If Yes, Give Year or Dates.			1 ☐ Yes 2😿 No					Specify:b			
72 hc	Completed	(Specif	15. Decedent's Ed fy only highest grad	de completed)		(Give	dent's Usual Occupa kind of work done d O NOT use retired)	ation <i>luring mos</i>	t of workin	g		ind of Busin			
withir withir giene generate rer the		Elementary/Second	dary (0-12)	College (1-4 or 5-	+)		teache	r			Da	y Car	re		
Yland Ild be filed Mental Hy narked ott	년 Be	17. Father's Name (Fir.								(First, Middle,		Surname)			
ould build build build build Mei	ľ	Leon Pi		ne Print)		10b Mailin	ng Address (Street a			Reas		Town Chat		-del	
d 2 shoualth and a 27 is n	1	Edward	,	,			Haverf				-			1980	8
Ore, le 1 and t of Hea if item or othe	1	20a. Method of Dispos		Removal from State	20b. Plac	ce of Dispo	osition (Name of natory or other place			ate		ocation - Cit			
altimol mit. Page 1 partment of portant: If i y injury or c		4 Donation 5	Other (Specify	)	Ivy		1 Cemet								
Departing the polynomial of th		21. Signature of Fa	Keke I	VISI	who had	/ IS	Ne Mods ervices	208	F	35th	St	uary Wilm	&Cr	emat	ion 802
		23a. Part 1. Priter the shock or heart t	disease, or comp failure. List only or	cations that caused e cause on each line	the death.	Do not erit	er the mode of dying	g, such as	cardiac or	respiratory ar	rest,			Approximate Interval Betv	e ween
Physician. Medica	-	Immediate Cause (Fir disease or condition resulting in death)	nal L	a. Due to (or as a		4 - 7	1 marca	720						Onset and D	reath
Examine				Due to (or as a	consequer	nce of):	e de bed							i	
_ =	ije.	Sequentially list cond if any, leading to imm cause. Enter Underlyi	ediate .	b. Dual to (or as a	consequer	sour city:	40 AT DIA 1.800							- waa	
ecutec and -trans	Xan	Cause (Disease or inj that initiated events resulting in death) Las	ury	c. Due to (or as a	consequer	oce off:							_		
route be executed physician and sthe burial-transit	edical Examiner	resulting in occurry co.		d	conseque	100 017.							,		
6 / 00 ifficate b ng physi as the l		IF FEMALE:		d									$\perp$		
th certification transfer as	ian/I	23b. Was decedent pr in the past 12 mg	cgilant		2 🔲 Fetal d	leath 3	Ectopic pregnancy	у			- 1	23d. Date o		•	
ords, F.O. BOX 08 (requires that the death certific been signed by the attending I should be detached for use as	Physician/M	1 Yes 2 9 Unknown		4 ☐ Pregnant at 9 ☐ Unknown	time of dea	ath 5∟	J Other (specify)					Month		Day Y	'ear
that the gned by se deta	by P	Part II. Other significa	ant conditions co	ntributing to death bu	t not result	ing in the υ	inderlying cause give	en în Part	1.	23e. Did t	obacco u	ise contribu	te to the	cause of de	eath?
oquires	ted									1 🗆	Yes 2	□ No 3 (	Proba	ably 4□ t	Jnknown
TECOTOS, The law requires ate has been sig	Completed									24a. Was auto		prio	r to com	sy findings a pletion of ca	
an: The tifficate tor, pa	Be	25. Was case referred	to medical				26 Pla	ace of Dear	th <i>(Check i</i>	1 🗆 Yes		) 1 <u> </u>	Yes 2	No	
VIII hysicia nis cer I direc		examiner?	No	lospital: 1 XInpatie	nt 2 🗆 EF	R/Outpatier	nt 3 DOA Othe	·		ne 5 🗆 Resid	dence 6	☐ Other (5	Specify)		
I OI Jing Pl Affer th funera	ate		5 Pending	28a. Date of injur (Month, Day,	y Year) 28	Bb. Time of injury	work	?		Bd. Describe h	now injury	/ occurred			
Attendir r death. ector: Af	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigation  6 Could not be determined	28e. Place of Injur	ry - At home	e, farm, str		Yes 2□	_	8f. Location (S	Street and	d Number o	r Rural F	loute Numb	er.
ital or us afte		4 🗆 Homicide	Geterrinied	building, etc.	(Specify)					City or Tov					
LIVISION OF VITAL RECORDS, P.O. BOX 08 of the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 L	_¹Medical Examin	ician: To the best of r ner: On the basis of ex e Practitioner: To the	amination a	nd/or inves	tigation, in my opinio	n, death oc	ccurred at t	he time, date a	and place	, and due to	the caus	e(s) and mar	ner stated.
To the comp	2	29b. Signature and titl		- Traculation to the	best of my	Niowiedge	29c. License		te and plac	e, and due to		te signed (M			
			1	5 mm	7		100566	52			Sepi	ilintel	r 30	m 2	011
		30. Name and address	set person who/co	ompleted cause of de				7_ 31.1-			2 3 4				
	ate	31. Date filed (Month,	JCT 032	32. Registra	r's Signatur	e e	Ra, Rand	ie MIT	Win &	MO O	×11.3.	<del>}</del>			
Regist	rar		201 03 2	012 Penn	de ,	1.	backel								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	Sta	ate of M	larylan		rtmen <i>tificate</i>			and M	lental Hy	_	20	112	3376	9
			Registrar  1. Decedent's Name (First, Middle)	I act)			Cer	inicate	ט וט :	eam			Reg. No.	۷. ر	116		
	Physicia			,								2. Date of De Month Septemb		6 20	Year,	3. Time of Death 6:00 A M	
	Medic Examin		Talmadge O. Nu 4a. Facility Name (if not institution,		nd number)			4b. City, 7	Town or l	ocation o		Берсеш		County o		0:00 A	_
	LAGIBIII	GI	Wilson Health							ersbı			40.		tgome	rv	
	Funeral	4		6. Sex	7. Ad	ge (In yrs. la	ast birthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of Birt	th	T	n Diethal	on Ctata or Familia	_
	Director		429-50-9435	1 🛛 M 2	□F	8	30 Yrs.	Months	Days	Hours	Min.	Nov.,	Year 19	31	Countr	Arkansas	
	D ow		Usual Residence of Decedent  10a. State 10b. County			10- 04	T1										_
	-f sh	cto					y, Town or Loc								10	d. Inside City Limits	
	r 28a	Sire	Maryland Montgo	mery		G	Germant		0 1							1 🗌 Yes 2 🗓 No	_
	ith th	Funeral Director						10f. Zip		07/			-		nat Count	•	
	mus 2	nue	11 Steeple Cou		s Decedent	Ever in II S	2 113 M	las Dacada		874	sin? (Spo	cify Yes or No-			d Sta		_
0	or ite	by Fi	Never Married 2 Marr	Arr	ned Forces? Yes 2	No Kor	cea lis. Vi	Yes, speci	fy Cuban	, Mexican	, Puerto	Rican, etc.)			- America , White, et		
9500-61212	s afte ral", Exar	q pe	3 X Widowed 4 ☐ Divorced	If Y	es, Give ar or Dates.	110	1	☐ Yes 2	. No	Specify:			5	Specify:	Whi	te	
<u>-</u>	hour natu dical	lete	15. Deceden				16a. Deced	ent's Usual	Occupa	tion			16b. Kir	nd of Bus	iness Indu	ıstry	_
7	in 72 e. nan "	Completed	(Specify only highe: Elementary/Seconday (0-12)		lege (1-4 or	5+)	life. DC	ind of work NOT use	retired)	inng most	of workii	ng	I:	nter	nal E	levenue	
7	with ygien her tl				4		Aco	count	ant						Servi	.ce	_
yland	e filec stal H ed ot	To Be	17. Father's Name (First, Middle, L	*								(First, Middle,		urname)			
<u> </u>	uld bu 1 Mer narke natic		William Lee Nu									arl Lin					_
Mar	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  The of Health and Mental Hygiene.  The firm 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationsh		•		4.					Route Numbe				ide)	1
ص ص	and Healt		Dereasa Knudse: 20a. Method of Disposition	1/Daug	nter	20h P	Place of Dispos	<del>-</del>		urt,		nantown Date			ity or Tov	n State	_
ם פ	age 1 int of t: If ii		1 🗶 Burial 2 🗆 Cremation		al from State	, C	emetery, crem	atory`or otl	her place		_				-		
baitimor	permit. Page 1 a Department of B Important: If its any injury or of		4 Donation 5 Other (S	1	*. 4.	Sha						3/2012			Knob	, AR	-
g	permi Depar Impor any ir once.		Ruge M	25Mi	Vline	O MO	1202 10	) F	Deer	Parl	'DeVo	ol Fune	ral !	Home	ra N	D 20877	Į
			23a. Part 1. Enter the disease, or	complication	s that cause	d the death								. SDu		Approximate	_
~ F	Physician/		shock, or heart failure. List of Immediate Cause (Final				Tila	611	16	-Lui	14	n 1/				nterval Between Onset and Death	7.
	Medical		disease or condition resulting in death)	a	Due to (or as	a consequ	uence of):			gan	•					control	4
	Examiner		Commentally liet and discon	h	Cash	na	level uence of): sy a	Elez	40	lexe	201	l			İ		
	-	ine	Sequentially list conditions, if any, leading to immediate	D	Due to (or as				0								
	cuted ind transi	xam	Cause (Disease or iinjury that initiated events	c											-1		_
	ate be executed bhysician and the burial-transit	dical Examiner	resulting in death) Last	Ĺ	Due to (or as	a consequ	Jence ot):										
3	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  within 24 hours after death.  within 24 hours after death.  completed filled in by the funeral director, page 2 should be detached for use as the burial-transit			d												<u> </u>	
00	ertific ding se as	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If y	es, outcome	of pregnar	ncy							ad Data	of deliver	,	
XO2	aath o atten I for u	cial	in the past 12 months?  1  Yes 2 No	1 E	Live Birth Pregnant	2 🔲 Feta at time of d	l death 3 🗆 death 5 🗔	Ectopic pr Other (spe	regnancy ecify)					Mont		/ ay Year	
ם	the de	Physician/Me	9 Unknown	9 [	Unknown												_
י י	that ned to e deta		Part II. Other significant conditio				_		,			23e. Did to	bacco us	e contrib	ute to the	cause of death?	
Š.	quires en sig	Completed by	Appertent	err.	desti	ary a	ofren	att	ron	44	nt	1 🗆 '	Yes 2	No 3	☐ Proba	bly 4 🗌 Unknown	
ecoras,	aw rec as ber 2 sho	blet	Polycy tick	dney	duces	we,	Diahi	tee I	I(ês	un	len)	24a. Was a				y findings available pletion of cause of	٦
ĕ	The Iz	E O	stevenos	ex 4	nial	fels	illete	m.f	ine	ste	we	_ perfo	rmed? 2 No	de	ath?		
VITAI	sian; ertific ctor,	Be (	25. Was case referred to medical examiner?			0				ce of Death	h (Check	only one)					
>	hysion this on al dire	유	1 Yes 2 No	Hospital	1 ∐ Inpat		ER/Outpatient			4 🗀 Nu	rsing Hor	ne 5 🗌 Resid	lence 6	Other	(Specify)		
0	ling F	ate	<ul><li>27. Man r of Death</li><li>1 ✓ Natural 5 ☐ Pending</li></ul>		. Date of inju (Month, Da	ıry y, Yea <i>r</i> )	28b. Time of injury		c. Injury a			8d. Describe h	ow injury	occurred			
VISION	death death stor: /	Certificate:	2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could r	ot be	Place of Ini	ury - At box	me, farm, stre	M at factory		es 2 🗌		10f Logation /C	troop and	Alumban	on Dissal F	auta Numbau	_
	lor A after Direct	Ç	4 ☐ Homicide determi	ned 200	building, et			st, lactory,	onice		- 4	8f. Location (S City or Tow		ivumber	or nurai n	oute Number,	
ַנ	spita hours neral d filled	Medical	29a. Certifier 1 Certifying	Physician: To	o the best of	my knowle	edge, death or	ccured at the	ne time, o	date and p	olace, and	I due to the ca	use(s) and	manner	as stated.		1
	in 24 in 24 in Pleter	Med	(Check 2   Medical Exonly one) 3   Certifying	a <b>miner:</b> On	the basis of e	examination	n and/or investi	gation, in m	y opinion	, death occ	curred at	the time, date a	nd place,	and due to	o the caus	e(s) and manner stated ed.	d.
	Vith Vith Co.		29b. Signature and title of certifier	,		1			License r						Month, Da		٦
	4+1		1 H. Rehert	buix	chh	selu	us		04	413	7		Sepi	tem	però	16,2012	
			30. Name and address of person w	ho complete	d cause of c	leath (Item)	23a) (Type, Pr	int) 30	IR	USS	ELL	AVEN	1618	2018	HM		
	Stat		<ol> <li>Date filed (Month, Dav. Year)</li> </ol>		32 Registr			617	-11	ITCK	را ک	KO,M		XU 0	' (		$\dashv$
	Registra	-	OCT 02 2	012	Desaus	المر ب	. par	Ked.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ Nickerson Roxie Burchette 09 2:35 A M 20/2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OMICO 9. Birthplace (State or Foreign If Under 1 Year If Under 8. Date of Birth Age (In vrs. last birthday, **Funeral** Months Davs Hours Min (Month, Day, Year) 240-52-3030 Director 1 🗆 M 2 🕱 F 88 01/01/1924 North Carolina Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County must be notified at Director 1 Yes 2 No Maryland Pittsville Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a Funeral 21850 USA 6671 Friendship Road ral", or items ? Examiner mus death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc ģ 1 Never Married 2 Married Notice, Mickerson altimore, Maryland 21215-0036 Yes 2 X No 1 Yes 2 X No Specify Specify "natural", Completed 3 X Widowed 4 Divorced Year or Dates White permit. Page 1 and 2 should be filed within 72 hours IDepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any i-jury or other traumatic event, the Medical Ionce. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Shirt Factory Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Clemintime Childers Walter Luffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6671 Friendship Rd., Pittsville, MD 21850 Hubert R. Burchette/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Wicomico Memorial 10/3/2012 Salisbury, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Holloway Funeral Home Professional Association ture of Funeral Service Licensee 4. Morryson CFSP 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): and the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Be Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month 4 Pregnant Pregnant at time of death 1 Yes 2 V detached signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably director, page 2 should peen 24a. Was an Were autopsy findings available prior to completion of cause of has autonsy performed death? After this certificate 21 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? PILE မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director; Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) ed cause of death (Item 23a) (Type, Print) NSHOPE DRY SAUSBURY MDZIKOU 2 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 30ay 2012 ear Elizabeth Golden Collins Oldenburg 7:25P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Burtonsville Montgomery Sanctuary at Holy Cross 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours May 28,1908 218-50-5054 104 Maryland Director 1 □ M 2 F Usual Residence of Decedent "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Beltsville Maryland Prince George's 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20705 10405A 46th Avenue, #304 United States 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2X No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify. White Specify. 3 X Widowed 4 ☐ Divorced Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) Decorator private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William G. Collins Rosetta Glassglow Cord 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai Claudette Hoover -Niece 11052 Chambers Court Woodstock, Maryland 21163 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Fort Lincoln Cemetery 10/8/2012 1 X Burial 2 Cremation 3 Removal from State Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Bonald AveressBorgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final 10 days Physician Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe Hypertension; Polio; Hypotyroidism 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 1 ☐ Yes 2 ☑ No filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of De h (Check only one) Hospital: Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: injurv ✓ Natural 5 Pending after death. Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nyrse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) the 29c. License number ٥ 29d. Date signed (Month, Day, Year) D25344 aist October 5, 2012 30. Name and address of person vho completed cause o∜death (Item 23a) (Type, Print) 3905 National Drive,#220 Burtonsville, Maryland 20866 Ginsberg, M.D. 32. Registrar' Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Putnam A tober ever Physician/ 012 Medical 4a. Facility Name (if Not institution, 4c. County of Death Examiner Town, or Location of Death Baltimore Hopkins JOHAS If Under 24 Hrs. 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Hours 75 Director 341-30-8634 1 □ M 2 🗶 F 07/15/1937 Illinois Usual Residence of Decedent 28a-f show 10d. Inside City Limits at 10a. State 10b County 10c. City. Town or Location with the Manyland Director must be notified 1 Yes 2 X No St. Mary's Maryland Great Mills 10f. Zip Code 10g. Citizen of What Country? 0 10e. Street and Number items 23a Funeral United States 45909 Church Drive 20634 death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian Examiner Black, White, etc. o. by 1 Never Married 2 X Married Yes 2X No Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene.
is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 4 Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, မ traumatic Nicholas Bowman Bessie Gertrude Irvine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sho Department of Health an Important: If item 27 is any injury or other trau once, 24579 Spriggs Court, Hollywood, MD 20636 Debra Zurkowski/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2x☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Brinsfield-Echols Cr 10/05/2012 Charlotte Hall, MD Signature Funer Servicion Fune 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Renal Immediate Cause (Final FNA 169 Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any least to be cause. Enter Underlying Examine Due to lor as a consequence of or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury that initiated events and I-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No for Day Year Month Pregnant at time of death 1 Yes 2 signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 11 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury
(Month, Day, Year)
28b. Time of injury
injury
28c. injury 1 🗌 Yes 2 X No ဂ funeral 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) October 1st, 2012 RES-060 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 800 or leads St, Baltimore, MD, 21287 8) eme Kalathiya 31. Date filed (Month Registrar's Signatur

DHMH 17 Rev 06-2011

State

Registrar

OCT 0 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State	State of I	Maryland	d / Depa	rtment of F tificate of D	lealth and		_	012	33768	5
	_		Registrar  1. Decedent's Name (First, Middle, Las	st)		Cer	incate or L	Caur	2. Date of De	Reg. No.		3. Time of Death	٦
	Physicia Medic		Gilda Lucy Pol	letto					Month Septem	ber 30	Year 2012	1:15 p <sup>M</sup>	
	Examin		4a. Facility Name (if not institution, give	street and number	)		4b. City, Town, or	Location of Deat	th	4c. Cou	nty of Death		٦
Marine S. C.	/		Sunrise Assisted					r Spring			ontgom		_
	Funeral Director		5. Social Security Number 6. S 045-12-7554		Age (In yrs. Ia 89		Months Days	If Under 24 Hrs Hours Min			Cour	**	
			Usual Residence of Decedent	□ M 2 <b>K</b> F		Yrs.			Aug. 6	, 1923	C	[	╛
	shov	ğ	10a. State 10b. County		10c. City	, Town or Loc	ation					10d. Inside City Limits	
	Mary 28a-1	Director	MD Montgo	omery		Silver	Spring					1 ☐ Yes 2 ☐ No	_
	th the		10e. Street and Number				10f. Zip Code 20902	1		10g. Citizen JSA	of What Cou	ntry?	
	ms 2	Funeral	1514 Gridley Land	12. Was Deceder	t Ever in II S	13 V	/as Decedent of H				Race - Americ	an Indian	$\dashv$
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show enty injury or other treumatic event, the Medical Examiner must be notified at once.	2	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces 1  Yes 2 If Yes, Give Year or Dates	s? K No	If	Yes, specify Cube	ın, Mexican, Puer	to Rican, etc.)		Black, White,		
5-0	2 hour	plet	15. Decedent's E (Specify only highest gr			(Give k	ent's Usual Occup ind of work done o	ation during most of wo	orking	16b. Kind o	f Business/In	dustry	1
7	thin 7.	Completed	Elementary/Secondary (0-12)	College (1-4 c	or 5+)		NOT use retired)	rvisor		1	NIH		
0 0	ed wi Hygie other ent, t	a	17. Father's Name (First, Middle, Last)			ora:	res super		ame (First, Middle,	Maiden Sum	ame)		٦
ā	l be fil lental rked tic ev	욘	Frank Scalo					Josej	phine Ri	tino			
ary	12 should be file lith and Mental H 27 is marked o r treumatic eve	ı	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	g Address (Street	and Number or R	ural Route Numbe	r, City or Tow	n, State, Zip	Code)	٦
Σ.	nd 2 sealth m 27		John Matthew Pol	letto/Sor		<u> </u>	Gridley	Lane, S:		· · · · · · · · · · · · · · · · · · ·			4
ore	ge 1 a nt of H if ite or ott		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from Sta	te Ca	lace of Disposemetery, crem	sition (Name of natory or other plac leaven	ce) Oct	Date t. 4,		on - City or T		
Ē	lit. Pagintmer intmer intant njury		4 Donation 5 Other (Speci	**	1 64	Cer	netery		2012			ng, MD	4
Ba	Depa Impo eny i		21. Signature of Funeral Service Licen	Ores	- Da						Inç. Spring	,MD 20901	_
			23a. Part 1. Enter the disease, or com- shock, or heart failure. List only of	plications that cau one cause on each	sed the death line.	n. Do not ente	r the mode of dyin	g, such as cardia	ic or respiratory ar	rest,		Approximate Interval Between Onset and Death	1
- 1	nysician/ Medical	H	Immediate Cause (Final disease or condition resulting in death)	a. Advance							$\rightarrow$	yrs	4
	Examiner		resulting in deality	Due to (or	as a consequ	ence of):							
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequ	ence of):							$\dashv$
	uted dansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C						_			
	Diriginal of		resulting in death) Last	Due to (or	as a consequ	ience of):							
8	physician end sthe burlal-transit	dical		d									$\exists$
687	eath certifice ettending pl	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	ne of pregna	ncy				224	Date of deliv	(en)	٦
ŏ	etten a for u	iciar	in the past 12 months?	4 🔲 Pregnar	t at time of c		Ectopic pregnand Other (specify)	cy		230.	Month	Day Year	
. B	requires that the des been signed by the e should be detached	hys	9 Unknown	9 📙 Unknow									
9.	s that gned l	by F	Part II. Other significant conditions									he cause of death?	
ds,	aquire sen si	ted	Hypertension, Ar		erotic	_Card1	ovasculai	r Diseas	e,			bably 4 🗆 Unknown	
000	has be	nple	Ambulatory Dysfu	nction					24a. Was			ppsy findings available ompletion of cause of	
æ	r. The icate r, pag	ខ	25. Was case referred to medical						1 🗌 Yes	2 No	1 🗆 Yes	2 🗆 No	4
lita	sicier certif lirecto	o Be	examiner?  1  Yes 2  No	Hospital:		ER/Outpatier	Oth	lace of Death (Ch	Home 5 Resi	damas 6 181	ssist	ed Living	٦
<del>6</del>	g Phy er this neral c	e: 10	27. Manner of Death	28a. Date of	njury	28b. Time of	28c. Injur	y at	28d. Describe			practitly	٦
LO O	ath. er: Aft	ficat	1 Natural 5 Pending 2 Accident Investigation	on .	Day, Year)	injury	M 1 □	Yes 2 No					
Division of Vital Records, P.O. Box 687	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of	Injury - At ho etc. (Specify		eet, factory, office		28f. Location ( City or To		mber or Rura	il Route Number,	
<u></u>	pital ours a erai C		29a. Certifier 1 X Certifying Ph	vsician: To the best	of my knowl	ledge death o	occurred at the tim	e, date and place	and due to the c	ause(s) and m	nanner as sta	ted.	i
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use as the burlal-transic.	Medical		niner: On the basis	of examination	n and/or invest	tigation, in my opini	on, death occurred	d at the time, date	and place, and	due to the ca	ause(s) and manner state	жd.
		_	29b. Signature and title of certifier	1112001			29c. Licens			29d. Date sig			
	10		▶ K. Luyaund	NVVVV			D	53367		Octob	er 1,	2012	
	,		30. Name and address of person who Shyamsundar Raja	n, MD	of death (Item	orest	Glen Roa	d, Silve	r Spring	, MD 2	0910		
	Sta Registr		31. Date filed (Month, Day, Year) 0CT 02 20	12 3. Reg	strar's Signa	ture day	Ked.						

		Ple	ease 1	Type or	Print in	n Blac	k In	idelible Ink	c. Ens	sure A	II Copie	s A	re Leg	ible.		
		For		State of	f Maryla	and / D	epa	artment of H	lealth	and N	/lental Hy	gier	ne			
		State Registrar				(	Cen	tificate of L	Death			Reg. I	No. 2	1 2	3	3767
Physicia	in/	Decedent's Name (First, Mid	ldle, Last)	Good	rao Lo	a Daf	for	ah a waa w			2. Date of De Month		Day	Year		of Death
Medio		4a. Facility Name (if not instituti	ion dive st			e PUI	Ter	nberger	Lacation	of Dooth	<u> Octobe</u>			12	112:2	2 P M
Examin	er	20526 Troving						4b. City, Town, or	iers t			] '	4c. County			
Funeral		5. Social Security Number	6. Sex		7. Age (In yr:	s. last birth	day)	If Under 1 Year	If Unde	r 24 Hrs.	8. Date of Bir			9. Birth	gton	e or Foreign
Director		217-32-7086		M 2 🗆 F	7	6 Y	rs.	Months Days	Hours	Min.	(Month, Da			Cou	arylaı	nd
ind show	'n	Usual Residence of Decedent 10a. State 10b. Cour	_		10c.	City, Town	or Loc	ation			mag. L.	0,1	300		10d. Inside	
Aaryla 8a-f s tified	rect	Maryland Was	hingt	con				Hag	erst	own					1 🗆 Y	res 2 X No
a or 2 be no	ä	10e. Street and Number		11.0				10f. Zip Code	1740			10g.	Citizen of V		intry?	
th with ms 23 must	<b>Funeral Director</b>	20526 Troving							1742				U.	S.A.		
er dea or itel niner	by Fu	11. Marital Status 1 Never Married 2 X N		12. Was Deced	dent Ever in ces? 2  No A	u.s. <b>rmv</b>	13. W	Vas Decedent of His Yes, specify Cubar	spanic Or n, Mexica	rigin? (Spe an, Puerto	cify Yes or No- Rican, etc.)	•	1	e - Ameri k, White,	can Indian, etc.	
rs afte ıral", Exar	ed b	3 Widowed 4 Divord			tes Kore		1	☐ Yes 2 🄀 No	Specify	<b>y</b> :			Specify:	Wh	ite	
2 hou "natu edical	plet	15. Dece (Specify only hig	dent's Edu ghest grade					ent's Usual Occupa		st of worki	ing	16b.	Kind of Bu	ısiness/Ir	idustry	
ithin 7 ene. • than	Completed	Elementary/Secondary (0-12	2)	College (1-	4 or 5+)	"		NOT use retired)					Rest	במווב	nt	
iled w Il Hygi other	Be	17. Father's Name (First, Middle	e, Last)				- 1	anager	18. Moti	her's Name	e (First, Middle,	, Maide			11 6	
d be f Menta arked atic ev	은	Albert Poff	enber	rger						Vio	let Mo	nni	nger			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relatio Katrina Poffe			Wife)	19b. l	Mailing	g Address (Street a	nd Numb	er or Rura	Route Numbe	er, City	or Town, Si	tate, Zip	Code)	217/2
and 2 Health em 27		20a. Method of Disposition	ine i G	(					:							
age 1 ent of it: If it y or o		1 💢 Burial 2 🗆 Crematio	on 3 🗆 R	lemoval from				sition (Name of natory Mellio Y 1	a1	Oct.	13, 2012	l	Location -	•	own, State , Mar	vland
mit. P. sartme sortar injur e.		4 Donation 5 Othe  21. Signature of Funeral Service			is <sup>MO1</sup>	111	22.	Park Name and Addres	s of Facil		J.L.					
permi Depar Impor any ir		Jalle	te	- DM	is not	717	12	.525 Brad	bury	Ave.						
		23a. Part 1. Enter the disease, shock, or heart failure. Lis	or complications	cations that ca	aused the de	eath. Do no	t enter	r the mode of dying	g, such as	s cardiac c	or respiratory ar	rest,			Approxim	ate etween
Physician/		Immediate Cause (Final disease or condition	a		_un	9	C	ancer	<u> </u>					6	Onset and	
Medical Examiner		resulting in death)		Due to (d	or as a conse	equence of)		2.4	)						1 00	.10.
	ner	Sequentially list conditions, if any, leading to immediate	b	Due to (c	or as a conse	equence of)	7	sema						1	ang	yeur
uted id ansit	ami	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>5</b> .				·								V	
executed ian and urial-transit	al Examiner	resulting in death) Last		Due to (d	or as a conse	equence of)	):									
ate be ohysic the bi	dica		d											$\dashv$		
ertific iding p	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23	3c. If yes, outo	ome of preg	inancy							00 d D+4	5 -1-15		
eath c atten d for u	iciai	in the past 12 months?		1 Live E 4 Pregn	Birth 2□ F lant at time o	etal death		Ectopic pregnancy Other (specify)	У	_			Mor	e of deliv nth	Day	Year
the d by the tacher	hys	9 🗌 Unknown		9 Unkne	-											
s that igned be de	by	Part II. Other significant cond	itions con	tributing to de	ath but not i	resulting in	the un	nderlying cause give	en in Parl	t I.		/			he cause of	
equire een s hould	Completed										14	Yes				Unknown
has b	mpl										24a. Was auto		1		psy findings empletion of	
n: The ificate or, pa		25. Was case referred to medic	al I					OF DIA	oo of Do	ath (Check	1 🗌 Yes	2 🖫			2 No	
ysicia is cert direct	To Be	examiner? 1  Yes 2 No		ospital:	npatient 2	☐ ER/Outp	patient	Othe	r:		me 5 Resid	dence	6 ☐ Othe	r (Snecifi	v)	
ng Ph ter thi ineral	ite: 1	27. Manner of Death 1 ☑ Natural 5 ☐ Pen	ding	28a. Date o		28b. Tin	ne of	28c. Injury work	at		28d. Describe				7	
tendii Jeath. tor: Al the fu	ifica		stigation					M 1 🗆 '		No						
or At after c Direct	Certificate:		rmined		of Injury - At g, etc. <i>(Sp</i> ec		n, stree	et, factory, office		1	28f. Location (\$ City or Tov			r or Rura.	l Route Nun	nber,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	edical	29a. Certifier 1 Certifyi	ng Physic	ian: To the be	est of my kno	wledge, de	eath or	ccurred at the time	, date and	d place, an	nd due to the ca	ause(s)	and manne	er as stat	ed.	
he Ho in 24 I he Ful pleteli	Med	(Check 2 🔟 Medica	l Examine	r: On the basis	s of examinat	tion and/or i	nvesti	gation, in my opinion death occurred at th	n, death c	occurred at	the time, date a	and plac	ce, and due	to the ca	use(s) and n	nanner stated.
To the with Com		29b. Signature and title of certif	ier \	Fam	ilu			29c. License					ate signed		_	
MAGA		MAN	ad 1	и.7.	phy	pin	aw		056	78	6		JU		120	
3 Mil		30. Name and address of person	ΛΛ -	bila	of death (It	m 23a) (Ty	pe, Pr	9093	Ri dq	efiel	d Dr.	Sui	te 10	4 Fr	ederi 2170:	ck, MD
Stat	е	31. Date filed (Month, Day, Year	2012		gistrar's Sign	nafure	basi	Nat.								<i></i>
Registra	ır		LUIL	X Rock	un 1	U. 19	-									1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33768 State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 20 A M Medical 4b. City, Town, or Location of Death 4c. County of Death acility Name (if not institution, give street and number **Examiner** Charles La Plata 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 01/31/1938 Virginia Months Days Hours 1 M 2 D F 74 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 No MD Charles Waldorf 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? United States Funeral 20601 3565 Leonardtown Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. Yes 2 No Yes, Give 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Completed Year or Dates. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) PG Parks & Planning Supervisor 10 permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Thelria Shackelford Harvey Roles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8250 Coral Creek Loop, Hudson, FL 34667 Russell Roles/Brother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 CCremation 3 Removal from State 10/09/12 Alexandria, Metro. Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Raymond Funeral Svc., or Funeral Ser M01517 MD 20646 La Plata, Washington Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ ANCE disease or condition Medical resulting in death) Due to (or as a consequent Examiner 1275 Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Exami been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s autopsy performed 1 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Hospital မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending injury Accident 2 🗌 No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifier 29d. Date signed (Month,

State Registrar

7

Name and address of p

31. Date filed (Month

(Type, Frint)

erson who completed cause of death (Item

Registrar's Signa

		Ame	ended #19A 10/04/2 <b>Pleas</b>	012, RML, St. 1 Type or Print in	Mary's <b>Black In</b>	County delible.lpl	k, Ensure	All,Copie	s Are Lec	iible.
			_ State	e Type or Print in mend 23a per m State of Marylan		rtment of F		Mental Hy		33769
	Physicia	an/	Registrar  1. Decedent's Name (First, Middle, La	. /	Cert	incate of L	Jealii	2. Date of De	Reg. No.	3. Time of Death
	Medi Examir	cal	Lataben J. Shah  4a. Facility Name (if not institution, giv		-	4b. City, Town, or	Location of Death	Juctobe	4c. County	012 1156 Q M
	Funeral	P	5. Social Security Number 6.5	Sex 7. Age (In yrs. It	ast birthday)	If Under 1 Year	Plata If Under 24 Hrs.	8. Date of Bir	<u> </u>	9. Birthplace (State or Foreign
	Director	ı	729-01-5596 Usual Residence of Decedent	□ M 2 🛛 F 70	Yrs.	Months Days	Hours Min.	(Month, Da	ay, Year)	Country) India
346	aryland a-f shov	Director	10a. State 10b. County Maryland Charles		y, Town or Loca Plata	ation				10d. Inside City Limits 1 ☐ Yes 2X No
5	with the Maryland 23a or 28a-f sho ust be notified at	ral Dir	10e. Street and Number 9400 Chesapeake			10f. Zip Code 20646			10g. Citizen of V	
7	r death w r items 2 iner mus	y Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	6. 13. W	as Decedent of Hi	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Rac	e - American Indian, ck. White, etc.
5-0036	ours afte ttural", c	ted by	1 Never Married 2 😾 Married 3 Divorced	1 Yes 2 X No If Yes, Give Year or Dates.		☐ Yes 2 No			Specify:	Indian
( /	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's B (Specify only highest gi Elementary/Secondary (0-12)	coucation ade completed)  College (1-4 or 5+)	(Give ki life. DO	ent's Usual Occupa nd of work done d NOT use retired) Omemaker	ation luring most of work	king	16b. Kind of Bu	usiness/Industry
and ?	be filed vantal Hyg ked othe c event,	To Be	17. Father's Name (First, Middle, Last)  Chunilal Shah						Maiden Surname	<del></del>
Lotto Maryland	should and Me		19a. Informant's Name/Relationship (		19b. Mailing	Address (Street a	Kamla Sh	al Route Numbe	er, City or Town, S	tate, Zip Code)
\ n	of Health of Health fitem 27	Į,	20a. Method of Disposition	other-in-Law ah	lace of Disposi	tion (Name of		Date		City or Town, State
]Q(V) Baltimore	nit. Page artment o ortant: If injury or		1 ☐ Burial 2 💢 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Licen	"Cre	matory	-Echols	10/02	2/2012	Charlott	e Hall, MD
Ba Ba	permit. Departn Importa any inju	9	Lauxten C.	Echels, III	301	.95 Three	Notch F	load, Ch	arlotte	Funeral Home, P Hall, MD 20622
	Physician/		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition	plications that caused the death one cause on each line.	1.1	the mode of dying		or respiratory ar		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):	Infarcti		regivo	are av	YAS F
	ed	xaminer	Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ		Intarcei	011			
	ath certificate be executed attending physician and for use as the burial-transit	ш	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):					
8760	tificate b ng physi as the k	Medic	IF FEMALE:	d						
Box 68760	Attending Physician: The law requires that the death certificate be exer death.  sctor: After this certificate has been signed by the attending physician ast the funeral director, page 2 should be detached for use as the burial	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown	23c. If yes, outcome of pregnar  1  Live Birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3	Ectopic pregnancy Other (specify)	/		23d. Dat Mor	e of delivery nth Day Year
17122 S, P.O	es that the signed by	ρ Ω	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the und	derlying cause give	en in Part I.			ibute to the cause of death?  3 □ Probably 4 🕅 Unknown
A. Records	aw requi	Completed						24a. Was	an 24b. V	Vere autopsy findings available rior to completion of cause of
	an: The la tificate h tor, page	Be Con	25. Was case referred to medical			26 Pla	ce of Death (Chec	perfo	rmed? d	eath?
23 6, f Vita	Physicie this cert	၉	examiner? 1  Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2   1		3 DOA Other	4 🗌 Nursing Ho	ome 5 Resid	lence 6 🗆 Othe	
#23 H Division of Vital	tending leath. or: After the fune	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b	(Month, Day, Year)	28b. Time of injury	28c. Injury work? M 1 🔲 Y	at /es 2 $\square$ No	28d. Describe h	ow injury occurre	d
Divis	i ji te	al Cert	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stree	t, factory, office		28f. Location (S City or Tow	itreet and Numbe n, State)	r or Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	Medical	(Check 2 L Medical Exam	sician: To the best of my knowle ner: On the basis of examination se Practitioner: To the best of m	and/or investig	ation, in my opinion	<ol> <li>death occurred a</li> </ol>	t the time, date a	nd place, and due	to the cause(s) and manner stated
	To the vithin com	_	29b. Signature and title of certifier	M		29c. License				(Month, Day, Year)
6	0		30, Name and address of person who	completed cause of death (Item	23a) (Type, Prir		C13	- 005	2001	1/
(2	),RML Stat		Am + 7 ota /	32. Registrar's Signatu		IVE L	a riati	a, 111	1 406	16
	Registra	ir	OCT 0 3 2	UIZ Agrana	p. 90	ake				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ to be Mary Louise Shifler 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Meritus Medical Center Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min 220-03-1181 **Director** 1 □ M 2 🗶 F 97 April 18, 1915 Maryland Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location Director notified Maryland | Washington Boonsboro 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o dical Examiner must be Funeral 8507 Mapleville Road 21713 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 □ Divorced Specify: White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress Medica1 traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o 2 Lorenzo Martin Reeder Bessie May Sigler Reeder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i M. Sandra Shifler / daughter 205 Della Lane Boonsboro Maryland 21713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or otl Page 1 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Boonsboro Cemetery 10/08/2012 |Boonsboro, maryland permit. 21. Dignature of Funeral Service Dicer 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike Boonsboro, MD 21713 nter the disease, or complications heart failure. List only one cause Approximate Interval Between Onset and Death shock, or heart fail Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or i that initiated events burial-tran and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical that the death certificate be P.O. Box 68760 as the l IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 
Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŕ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an has certificate or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 1 Inpatient 2 A/Outpatient 3 DOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation Suicide 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year) Registrar

29b. Signature and title

29c, License number
D 44996

eppans Rd Boonsboro MD 21713

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Belle Smullen Lena Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death VICOMICO If Under 1 Year If Under 24 Hrs Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Director 218-16-6447 1 M 2 XX 87 02/24/1925 Maryland Usual Residence of Decede r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 10a State within 72 hours after death with the Maryland 10b County 10c. City, Town or Location Director 10d. Inside City Limits 1 XYes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 304 Troopers Way 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Completed 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) e 1 and 2 should be filed within 72 to f Health and Mental Hygiene.
If item 27 Is marked other than "1 or other traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Beautician Beauty Salon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Charlie Mitchell Lucinda M. Hudson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Becky S. Mason/Daughter 28826 Seaford Rd., Laurel, DE 19956 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any Injury or of Wicomico Memorial Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/4/2012 Salisbury, MD Park 22 Horrand Address of Facility at Home Professional Association CFSP 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Myoundalon disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Year Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burlar-transit completely filled in by the Innerial director, page 2 should be detached for use as the burlar-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Andra Stansis 1 ☐ Yes 2 ➡ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be ( 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) PYYOLA 9.29-12

(g TC)
State

Registrar
DHMH 17 Rev 06-2011

10)

32 Registrar's Signature

MILAGES

15 PO2

21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

CONSTRUCT

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:04 AM James Sappington Lyman q - 29 2012 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospice at the Lake Salisbury Coastal Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min 1 **X** M 2  $\square$  F **Director** 215-20-7982 86 03/29/1926 Maryland Usual Residence of Decec 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits with the Maryland Director notified 28a-f 1 X Yes 2 No Maryland Berlin Worcester 10e. Street and Number 10f. Zip Code appington 9 10g. Citizen of What Country? must be Funeral 23a 21811 101 Austin Circle USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Deceue... ed Forces? Yes 2 \( \subseteq No the Medical Examiner Black, White, etc. ö þ 1 Never Married 2 Married X Yes be filed within 72 hours after If Yes, Give Year or Dates. Navy 1 Yes 2 No Specify: "natural" Specify: Completed 3 X Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Clerical State of Maryland other of Health and Mental Hygi item 27 is marked othe other traumatic event, Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lyman Sappington Margaret Crotty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 310 Oakwood Rd., Edgewater, MD 21037 Maura E. Sappington/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1 ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place) Salisbury Crematory 10/2/2012 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD 1. Signature of Euneral Service Lice 22. Name and Address of Facility
Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last use as the burial-trar and Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed should peen 24a, Was an 24b. Were autopsy findings available page 2 s prior to completion death? performed hin 24 hours after death.

the Funeral Director: After this certificate 2 No 1 Yes Division of Vital 25. Was case referred to dical filled in by the funeral director, 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 ther (Specify) ဂ္ဂ 1 Yes 2 **N**o 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending 1 Natural Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one within To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print)

LIVE SIN

State Registrar

DHMH 17 Rev 06-2011

910

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Day Clifton S. Savage 1521 М 30 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Salisbury Wicomico Peninsula Regional Medical Centex If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months Min Country Director 214-66-8456 1 🛛 M 2 🗆 F 57 July 20,1955 VA Usual Residence of Decedent 27 is merked other than "natural" or items 23a or 28a-f show traumetic event, the Madical Examiner count to a different and the models. i and 2 should be filed within 72 hours after deeth with the Maryland f Health end Mental Hygiene. item 27 is merked other than "naturai", or items 23a or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits Director Wicomico Salisbury 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 614 Lake Street 21801 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Sanitation Laborer Poultry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Warren Fosque Sadie Savage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laverne Savage/wife 614 Lake St., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Depertment of H
Important: If ite
any injury or ott 20c. Location - City or Town, State cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Green Acres Mem Park 10/06/2012 Salisbury, MD 21. Signature of Funeral Ser 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 21801 23a. Part 1. En er the disease, of eximplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Carcinoma Larungeal Medical Examiner Multiple Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and I for use as the buriel-trensit or Attending Physicien: The lew requires that the death certificate be executed phases Due to (or as a consequence of): Physiclan/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav 4 Pregnant at time of death ate has been signed by the a page 2 should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N certificate 2 🗆 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, a B 25. Was case referred to medical of Vital 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 🗌 Yes မြ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Division М 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 12153776 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. CARROLL St. Salisbury MD. 21801 CRNP

Registrar

State

31. Date filed (Month, Day, Year)

02

2012

32. Aegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8 BETTY INEZ SEITZ 4 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Nicomico the DICE If Und 4 Hrs. Social Security Number Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Min Country) 212-28-6189 **Director** 1 🗆 M 2 ី🎗 F 83 24, 1929 NORTH CAROLINA Usual Residence of Deceden 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MARYLAND 1X Yes 2 □ No WORCESTER BERLIN 5 10e. Street and Numbe 10f. Zip Code 109. Citizen of What Country? 23a Funeral 9715 HEALTHWAY DRIVE 21811 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Armed Force Black, White, etc. 0 Completed by 1 Never Married 2 Married 2 🕅 No 1 Yes 1 ☐ Yes 2X No Specify. Specify. "natural" 3 X Widowed 4 Divorced Year or Dates WHITE traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, il Hygiene. I **other than** " Elementary/Secondary (0-12) 10 College (1-4 or 5+) SALESPERSON RETAIL SALES Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ဂ္ ALFRED JOHN COX MARY ALICE FOX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra WM. PAUL HAUGEN/SON 4134 SKY VIEW DRIVE, GLENVILLE, PA 17329 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Domation 5 Other (Specify) CREMATORY OF DELMARVA 10/1/12 DELMAR, DELAWARE 21. Signature Pun ral Service Licens 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, br heart failure. List only one cause on each line. Interval Between Onset and Death Ph<sub>sician/</sub> disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi Cause (Disease or Injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mop Day n signed by the at Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of death? After this certificate Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 27. Manne of Death filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Vilatural work? 1 Yes 2 No 5 Pending injury ☐ Accident ☐ Suicide Investigation 24 hours after death Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signatu 29d. Date signed (Month, Day, Year, ed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 29, 2012 Grace Deliah Stanley 1120 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisburg Rehabilitation + Nursing Ct Salisburg Wicomico Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Funera 8. Date of Birth 9. Birthplace (State or Foreign Hou*rs* Min. (Month, Day, Year) Director 222-07-3820 1 □ M 2**X**□ F 95 6-11-1917 NC show 10a. State ir than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director MD Mardela Springs 1 Yes 2 No Wicomico 10e. Street and Number 10g. Citizen of What Country? Funeral 11700 San Domingo Road 21837 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced Specify Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene, ent. If item 27 Is marked other than \* Elementary/Secondary (0-12) College (1-4 or 5+) q Production Worker Perdue Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ J.C. Spikes Hattie Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21801 Barbara Waller/Daughter 5660 Scottish Highland Cir, Salisbury, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) UM Cemetery 10-5-2012 Mardela Springs, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Salisbury, MD 21801 Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequenc -Examiner Sequentially list conditions, if any, leading to immediate cauce. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Grace Stan ley Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of 1 Yes 2 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2021No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Certifying Nurse Pactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and 29d. Date signed (Month. Day, Year) HB3 30 Name and ac se of death (Item 23a) (Type, Print) 200 Boro 11a 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

0 4 2012

OCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ruth Ann Sommers 6:25 AM 10 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Coastul Hospice at the Lake Salisbury Wicomica Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** (Month, Day, Year) Min. Director 208-28-4164 1 🗆 M 2 🗶 F 76 Usual Residence of Dece 09/18/1936 Pennsylvania ortent: If item 27 is marked other then "neturel", or items 23e or 28e-f show injury or other treumatic event, the Medical Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Wicomico Delmar 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21875 USA 9347 Colonial Mill Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give ð 1 Never Married 2 Married should be filed within 72 hours effer end Mental Hygiene. Maryland 21215-0036 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Non-Profit Coordinator Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health end Mental H Importent: If item 27 is marked out eny injury or other trans 18. Mother's Name (First, Middle, Maiden Surname) Ruth Ann Miller John William Entwistle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah J. Chermak/ Sister 7031 Brantley Dr., Salisbury, MD 21804 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/4/2012 Salisbury, MD Salisbury Crematory 21. Signature of Funeral Septice Licenses Thorioway Puneral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Onset and Death Immediate Cause (Final Physician/ ung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury Examiner Due to (or as a consequence of): ettending physician and I for use es the burial-transit To the Hospitel or Attending Physicien: The law requires thet the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Day Month ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Oct 3, 2012 H68413 and address of person who completed cause of death (Item 23a) (Type, Print)

Funaloli-Shechan D.o. PO BOX 1733 Sollsbury, MD 21802 HB6 31. Date filed (Month, Day, Year) State UCT () 4backe

Registrar

d

£3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1010 000	tificate of Death	Reg. No. 20	12 337
Physic edical Exan		1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year October 8, 2012	3. Time of Death 0130 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		
		Baltimore Washington Medical Center	Glen Burnie	Anne Arunde	
Funera Directo		5. Social Security Number 212-81-9803 6. Sex 1 M 2 N F 7. Age (In yrs. la	A4 1 5 1 1 A4.	1 Forei	
any		Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Location		10d. Inside City Limits
vfaryland 28a-f show any	1	Maryland Anne Arundel Sev	vern		1 Yes 2 No
nith the Maryland s 23a or 28a-f show	Director	10e. Street and Number 7846 Coldbrooke Drive	10f. Zip Code 21144	10g. Citizen of What Cou Pakistan	intry?
r death with	Finans	11. Marital Status  1 Never Married 2 Married Armed Forces?  1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.) White, etc.	ican Indian, Black,
urs after hural",	1	or Dates:	1 Yes 2 No specify:  16a. Decedent's Usual Occupation (Give kind of		nite
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other fraumitic event, the Medical Examinar must be notified as one	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use ret Student	Fducatio	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Re Co.	Saqaf Malik	Shamila	e (First, Middle, Maiden Surname) Zulfigar	
MD 21 id 2 should lith and Me m 27 is m	2	19a. Informant's Name/Relationship (Type, Print) Sagaf Malik -father	19b Mailing Address (Street and Number or 7846 Coldbrooke Drive		
l and 2 Health		20a. Method of Disposition 20b. P	rematory or other place)	Date 20c. Location - City or	
Baltimore, bermit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other Specify:	land National Mem. Park 10,		
Balt permit Depart Impor		21. Signaturé of Funéral Service Licensee	2D Name and Address of Facility ard 4400 Powder Mill 1	dt Funeral Home, P. Road Beltsville, Ma	A aryland20705
Physiciar /Medica		23a. Part I. Enter the disease of complications that caused the death. failure. List only one course on each line.	Do not enter the mode of dying, such as cardiac of	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
Examine	r	Immediate Cause (Final disease or condition resulting in death)  a. Asphyxia by hanging  Due to (or as a consequence of	):		56461
	٦	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of	):		
pa iso	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of	):	<del></del>	
760, foate be executed sphysician and the burial - transit	Medical				
760, icate be physical the buri	/Mec			23d. Date of deliver	•
lox 68 eath certif	sician	past 12 months?  1 Yes 2 No 9 V Unknown  1 Unknown	2 Fetal death 3 Ectopic pregnath 5 Other (Specify)	ancy Month	Day Year
P.O. B es that the de gred by the	4		sulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
ords, P.C. w requires that us been signed should be deta	vd be			1 Yes 2 No 3 Prol	
cords law requi	¹I 7				topsy findings available completion of cause of
tal Recision: The Certificate Certificate Cector, page			26.Place of Death (Check	1 Yes 2 ✓ No 1 Yes	es 2 No
Vita hysicia this cer	To Be	1 Yes 2 No 1 Inpatient 2	Othor	ng Home 5 Residence 6 Other	r:
Division of Vital Records, ta or Attending Physician: The law requirer as after death.  al Director: After this certificate has been sivel in Iv the funeral director nase 2 should be led in Iv the funeral director nase 2 should be	ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of Injury FOUND: Oct 7, 2012	28b. Time of Injury  FOUND:  1458 hrs  28c. Injury at Work?  1 Yes 2 ✓ No	28d. Describe how injury occurred Subject hanged	
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined (Specify) Single Fam	me, farm, street, factory, office building, etc.	28f. Location (Street and Number or Ru or Town, State) 7846 Cobrook Drive, Severn, MD	ıral Route Number, City
To the Hos within 24 h To the Fun	edical	29a. Certifier 1 CertifyIng Physician: To the best of my knowledg one) 2 Medical Examiner: On the basis of examination an and manner stated.			
->-	Ž	29b. Signature and title of certifier	29c, License number O.C.M.E.	29d. Date signed (Mo October 8, 2012	nth, Day, Year)
D W	-	30. Name and address of person who completed cause of death (Item)		OCIODEI 6, 2012	
O V		Zabiullah Ali, M.D. Assistant Medical Examiner	900 W. Baltimore Street, Baltimore,	MD 21223	
Regi	State		y area		

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Walter 11:15P M Taylor, Jr. 2012 September Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis - LaPlata Center LaPlata Charles 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) Hours Min Director 229-38-9745 1 **X** M 2 □ F 76 07/07/1936 Virginia 28a-f show 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland St. Mary's Clements è 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 23609 Budds Creek Road USA 20624 items 2 death v 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc "natural", or 1 Never Married 2 Married Completed by 72 hours after 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ♣ Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene.
is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Transportation Trucker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Walter Taylor Addie Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a tant: If item 27 is 23609 Budds Creek Rd., Clements, MD 20624 Faith B. Taylor/daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5 injury 4 Donation 5 Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 21. Signal une of Funeral Service Licental any -M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Dement Ph sician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner toolure to thrive Sequentially list conditions, Examiner if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other 2.XX)No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Certificate: 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury Accident Investigation after death Director / d n by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled n by 4 Homicide determined Medical 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title for certifie 29c, License number 29d. Date signed (Month, Day, Year) D070900 27 Reander Kaly 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6934 AV10400 BWO, SUHE B, COU Clam Burnie MD 2106 ) RMC 31. Date filed (Month, Day, Year) Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 27, 2012 Thomas Leroy Welch 7:22 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Center Clinton Prince George **Funeral** Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year, Director 218-14-3184 1 X M 2 □ F Usual Residence of Decede 05/23/1920 Benedict, MD itel Hygiene. ed other than "naturel", or items 23a or 28a-f show event, the Modical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Charles Benedict 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18517 A Street 20612 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 🖾 Yes 2 🗌 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ۾ 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Groundsman Electric Utility Co. Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) I and 2 should be flle f Health and Mentel H item 27 is marked ot မ Louis S. Welch, Sr. Ella Goldsmith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Margaret F. Welch / Wife Box35. Benedict, MD 20612 20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mary's Bryantown 10/01/2012 20a. Method of Disposition permit. Page 1 a Depertment of H Important: If ite any Injury or oth 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bryantown, Maryland 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. Signature of Funeral Service #M00817 30195 Three Notch Rd., Charlotte Hall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Coronar-1 Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): e. or use as the burlal-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Pregnant at time of death g 🗌 Unknown P.O. signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No ☐ Yes 2 V No director, Hospital or Attending Physicien: To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 1 No Other: 1 ☐ Inpatient 2 M ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Matural injury ours after death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, in 24 hours to the Funeral D' completely fille Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the within 2 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

6+1 RME

Division of Vital

Registrar

31. Date filed (Month, Day, Year, OCT 0 1 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wendell C. Pierson503 Surratts Road (Rt. 5), Clinton, Maryland 20735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Joseph Harold Wood 4:05 A M September 28, 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Leonardtown St. Mary's Hospital If Under 1 Year If Under 24 Hrs. Social Security Numb . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 215-38-9625 1 **X** M 2 □ F **Director** 74 Maryland September 12,1938 Usual Residence of Decedent or 28a-f shov notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 72 hours after death with the Maryland Director 1 Tes 2 No Lexington Park Maryland St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or Funeral USA 20653 48729 Far Cry Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces 1 ▼ Yes 2 □ No If Yes, Give 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. College (1-4 or 5+) Elementary/Secondary (0-12) Federal Government Computer Systems Analyst Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Elsie Buckler Wood Louis Webster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Informant's Name/Relationship (Type, Print) 48729 Far Cry Road Lexington Park, MD Wife Benita Marie Wood 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 
■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 10/03/2012 Mechanicsville, MD Mt. Zion Methodist Signature of Funeral Service License 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANDIONESPIRATORY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of, RYPERTENSION PULMONAN SEVERE To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records. Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? cate has autopsy performed? 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ျှ funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 09/28/2012 169683

12+1 Rme

State Registrar

Day, Year) 31. Date filed (Month OCT 0 2 2012

30. Name and address of person who completed, cause of death (Item 23a) (Type, Print)

notin



MD 20650

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 3378 | State of Maryland / Department of Health and Mental Hygiene

Stephen Robert Wy	COff 1- For State Registrar	State of Ma	•	partment of ertificate of		l Mental Hy		eg. No.	
Physician/ Medical Examiner	Decedent's Name (First,		ycoff				2. Date of Deat		3. Time of Death 0219 hrs
and the same of th	4a. Facility Name (if not ins 23309 Sugar Map	titution, give street ar			b. City, Town, or L California	ocation of Death		4c. County of t St. Mary's	Death
Funeral Director	5. Social Security Number 523-61-4149	6. Sex	7 11 1	s. last birthday)  R Yrs	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Bir	`   F	e. Birthplace (State or or oreign Country) Country) Arizona
any	Usual Residence of Deceder 10a, State 10b, Co	ent		ity, Town or Locati			111/13/	1973	10d. Inside City Limits
<b>È</b>	Maryland St.	Mary's	Cal	ifornia	10f. Zip Code	_	1 1	0g. Citizen of What	1 Yes 2 No
h the Maryland 3a or 28a-f sh otified at once I Director	23309 Sugar	Maple Co	urt		20619			United St	
or death with the Maryland or items 23a or 28a-f show must be notified at once. Funeral Director	11. Marital Status 1 X Never Married 2	Married Arm	Decedent Ever in ed Forces?  Yes 2 No	lf Y	s Decedent of Hisp es, specify Cuban,	Mexican, Puerto I		- 14. Race - A White, e	American Indian, Black, etc.
ours after satural", caniner ;	3 Widowed 4 15. Decedent's Education	Divorced If Yes, Giv or Dates: (Specify only highes		16a. Deceden	Yes 2 X No 's Usual Occupationst of working life.	on (Give kind of w		Specify: 16b. Kind of Busin	White ess/Industry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Elementary/Secondary (0		ge (1-4 or 5+) 2		ory Assoc	iate		Retail S	ales
21215-0 21215-0 weld be filed v Mental Hygi marked oth cevent, the I	17. Father's Name (First, M Albert Bradl 19a. Informant's Name/Rela	•			к	8.Mother's Name	Louell:	a Grosse	
MD 21 d 2 should lth and Me in 27 is ma To	19a. Informant's Name/Rela Chadron Lair				Address (Street Birch Wa			nber, City or Town, MD 2061	
iges I and it of Health it of Health it. If item other train	20a. Method of Disposition 1 X Burial 2 Cren		val from State	b. Place of Dispos crematory or oth	tion (Name of cem er place)	etery,	Date	20c. Location - Ci	
Baltimore, permit. Pages I an Department of He. Important: If ite	4 Donation 5 Oth	rvice Licensee	7	22. N	ame and Address	ofFacility Bri	insfield	d Funeral	am, Maryland Home, P.A.
Physician	23a. Part I. Enter the disease failure. List only one of	e, or complications to ause on each line.		ath, Do not enter th				nardtown, est, shock, or heart	Approximate Interval Between Onset and
Examiner	Immediate Cause (Final dis or condition resulting in dea	Due to (or	as a consequence						Death
niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying C	Due to (or ause	as a consequence	e of):					
uted nd ransit I Examiner	(Disease or injury that initial events resulting in death)		as a consequence	e of);					
50, te be executed sysician and burial - transit	UNPENDED  IF FEMALE:	AMEND	ED yes, outcome of pro	egnancy				23d. Date of de	livery
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate lynthin 24 hours after death. To the Fumeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bedieval Certification: To Be Completed by Physician/Me	23b. Was decedent pregnan past 12 months?	t in the 1 L	ive birth regnant at time of	2 Fe	al death 3	Ectopic pregnar	ncy	Month	Day Year
P.O. Bc that the des med by the a detached fo by Phys	Part II. Other significant co	3 0	Inknown ing to death but no	ot resulting in the u	nderlying cause giv	ven in Part I.			te to the cause of death?  Probably 4 Unknown
ords, P.C. w requires that as been signed be should be detailed by							24a. Was a	an 24b. We	re autopsy findings available
Division of Vital Records, tal or Attending Physician: The law requires as after death.  The Director: After this certificate has been signed in by the funeral director, page 2 should be ertification: To Be Completed	25. Was case referred to m	adical			26 Place	of Death (Check o	perfor 1 Yes	med? dea	th? Yes 2 No
F Vital Physician Tr this cert al directo	examiner?  1 Ves 2 No.  27. Manner of Death	Hospital: 1	Inpatient 2	ER/Outpatient	3 DOA	Other Nursing	Home 5	Residence 6 🗸	Other; Scene
ion of trending Ph leath. stor: After tree the funeral	1 Natural 5	Pending Sep	Date of Injury Month, Day Year) 29, 2012	28b. Time of In 0200 hrs			Subject shot	now injury occurred t by police	
Division C To the Hospital or Attending within 24 hours after death. To the Funeral Director: Af completely filled in by the fun edical Certification	3 Suicide 6 4 ✓ Homicide	Could not be	Place of Injury - At		t, factory, office bu		or Town, S		or Rurat Route Number, City fornia, MD
Divis  To the Hospital or A within 24 hours after To the Funeral Direct completely filled in t		ng Physician: To the Examiner: On the band nan							
M F S H S	29b. Signature and title of c		1		29c. License O.C.N			29d. Date signed September 3	(Month, Day, Year) 0, 2012
DRME OCME	30. Name and address of po Mary G. Ripple Mi	D-muhi Ch	cause of death (Ite		W. Baltimore	Street, Baltim	ore, MD 21	223	
State Registrar		(ear) 3 2012 3	2. Registrar's Sign	ature	K)				
DHMH 17 Rev 1/2001				ORIGINA					

2-07625	Please Type or P	rint in Black Indelible Ink. Ensure All Cop	ies Are Legible.			
Katherine Susan Wo		Maryland / Department of Health and Mental I				
	1- For State Registrar	Certificate of Death	Reg. No.	20	12 33	78
Physician/	Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death	~~~
Medical Examiner	Katherine Susan	Woodard	Month Day October 8, 2012	Year	1400 hrs	

atherine Susar	ı Wo	1- For State	tate of Maryla		tment of I		d Mental		-	2012	227
Physici	an/	Registrar  1. Decedent's Name (First, Midd	lle,Last)		mouto or E	Journ		2. Date of Dea		3. Tin	ne of Death
Medical Exami	Cal Examiner Katherine Susan Woodard						Month October 8	Day Yea 3, 2012	<sup>ar</sup> 14	100 hrs	
The state of the s		4a. Facility Name (if not institution, give street and number) 4b. City, Tow 21252 Winding Way Lexingto						eath	4c. County St. Mary		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.				If Under 1 Year	If Under 24	Hrs. 8. Date of Bi	rth (MM/DD/YYY)		(State or
Director		220-78-5192	1M 2_ <b>x</b> F	47	Yrs.	Months Days	Hours	Min. 01/04/	/1965	Foreign Ma Country)	aryland
ž.		Usual Residence of Decedent  10a. State 10b. County		Inc. City. T	own or Location					Land	-16 04 15-4
d IOW ABBY		,	Mary's	Toc. City, 1			a wle				Inside City Limits Yes 2 X No
Maryland 28a-f show	Director	10e. Street and Number	Haly S			ngton P	alk	1	l0g. Citizen of Wh		
0036 within 72 hours after death with the Maryland joine. her than "natural", or items 23a or 28a-f sho Medical Examiner must, be notified at once.		21252 Winding	Wá.y			20	653		US.	A	
th with	Funeral	11. Marital Status  1 X Never Married 2 M	12. Was Dec	cedent Ever in U.S. orces?		Decedent of Hisp specify Cuban,		( Specify Yes or No erto Rican, etc.)		- American Inc	dian, Black,
ter dea			1 Yes	2 <b>X</b> No			specify:	, , , , , , , , , , , , , , , , , , , ,	Specify:		
ours af Atural	d by	15. Decedent's Education (Spe	or Dates:		16a. Decedent's	Usual Occupation	on (Give kind	of work done	16b. Kind of Bu		y
5-0036 led within 72 hours afte tygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12)	College (1			of working life.		retired)			
-003 I withi giene.	E O	12 17. Father's Name (First, Middle	Last)		Domesti			ame (First, Middle,	Hous		
	Be C	Unknown	, ===-,			1.		Jean Lar		,	
imore, MD 21215-0036 Pages I and 2 should be filed within 7 ment of Health and Mental Hygiene. tant: If item 27 is marked other than or other traumatic event, the <u>Medical</u>	P	19a. Informant's Name/Relations	ship (Type, Print)		1		and Number	or Rural Route Nur	mber, City or Tow	n, State, Zip Co	ode)
물물물물		Melanie Woodan 20a. Method of Disposition	rd/ Daught		22330 ace of Disposition			reat Mil		20634 City or Town,	Otala
Baltimore, permit. Pages 1 a Department of He Important: If ite		1 Burial 2 X Cremation	n 3 Removal fro	om State Matti	matory or other	place) rdiner	="				
Baltimo permit. Page. Department o	1	4 Donation 5 Other Si 21. Signature of Funeral Service	pecify:	Funer	al Home,	P.A.Cremat	of Facility	0/10/2012			
Dep Dep	ŀ	Daniell W	Jard			Matti 90 Fenw	ngley- ick St	Gardiner reet Leon	Funeral nardtown	Home,	P.A. 20650
Physician (Medical		23a. Part I. Enter the disease, or failure. List only one cause	complications that ca on each line.	aused the death. D	o not enter the	mode of dying, s	such as cardi	ac or respiratory arr	est, shock, or hea	art Appr	roximate Interval ween Onset and
Examiner	ĺ	Immediate Cause (Final disease or condition resulting in death)		nal Asph							Death
v == 45		Sequentially list conditions,	b.	r donisequence or).							
	ine	if any, leading to immediate cause. Enter Underlying Cause		consequence of):							
sit sit	Examiner	(Disease or injury that initiated events resulting in death) Last		consequence of):							
iO, e be executed ysician and burial - transit	edical E	X UNPENDED	d.	23c.pt.II	,27,28a	-f.per	me, g93	3 11-5-12	2 sm		
60, ate be e hysicia e buria		IF FEMALE:		outcome of pregna			- ,0		23d. Date of	delivery	
Box 6876( e death certificate the attending physelfor use as the b	Completed by Physician/I	23b. Was decedent pregnant in the past 12 months?	ne 1 Live b	irth	2 Fetal	death 3	Ectopic pre	gnancy	Month	Day	Year
Box e death c the atten ed for us		1 Yes 2 No 9 🗸 Uni		ant at time of deatl	n 5 Other	(Specify)			30		
P.O. E es that the digned by the detached		Part II. Other significant condit	ions contributing to	death but not resi	ulting in the und	erlying cause giv	ven in Part I.	23e. Did to	obacco use contri		
S, P.C uires that n signed l		Acute alcoho	1 intoxica	ation and	l obesit	у			-or Harry	Probably 4	4 Unknown
cords law requi								_ 24a. Was autop	osy p	rior to completi	indings available ion of cause of
tal Recting The l								1 ✓ Yes	rmed? d 2 No 1	leath? Yes	2 No
Vital Rec hysician: The l this certificate l	Be	<ul><li>25. Was case referred to medica examiner?</li><li>1 Yes 2 No</li></ul>	Hospital:	npatient 2 E	R/Qutpatient 3		of Death (Che		Residence 6	Other Score	
n of \ding Phy	٤	27. Manner of Death	28a. Date		8b. Time of Inju		at Work?	28d. Describe	how injury occurre	ed ed	
Sion Attendideath.	atio	Natural 5 Pend 2 X Accident Inves	ting [		Ed 1300 H	rs 1 Ye	es 2 🗶 No	subjec wedged	t found between	upside bed and	down shelf
in b	Certification:	dete	a not be	e of Injury - At hom		actory, office bu	ilding, etc.	or Town, S	Street and Number tate 21252	Winding	te Number, City
Divis  Hospital or A 24 hours after Funcral Dire		4 Homicide (Specify) Fd:Residence Lexington Park, MD.  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
Di To the Hospital within 24 hours a To the Funeral I	Medical	one) 2 Medical Exa	miner: On the basis of and manner st	of examination and							)(s)
F > F 0	ž	29b. Signature and title of certifie				29c. License			29d. Date signe		r, Year)
		1/11 Z			ND	O.C.M	1.5.		October 9,	2012	
		30. Name/and address of person who completed cause of death (Item 23a)  Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223									
	- 4										

State 31. Date filed (Month, Day, Year)
Registrar 0 CT 1 0 2012

32 Registrar's Signature ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Frances T. Walker September 2012 9:22 A M Medical 4b. City, Town, or Location of Death
Annapolis Facility Name (if not institution, give street and number) Examiner 1888 Luce Creek Drive Anne Arundel . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Days Hours 257-40-2504 **Director** 88 1 M 2 X F Dec. 8, 1923 Kentucky 28a-f show "natural", or items 23a or 28a-f sho 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Annapolis Maryland 1 Yes 2 XXVo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1888 Luce Creek Drive 21401 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2XXMarried Yes 2 No f Yes, Give Saltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2XXNo Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 1944-45 th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Medicine 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mae (unknown) Ross Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1888 Luce Creek Drive Annapolis, Maryland 21401 item 27 Stewart Walker/husband other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/2/2012 Baltimore Crematory Baltimore, Maryland Veral Selvice Licensea 22. Name and Address of Facility John M. Taylor Funeral Home 0 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ Multi-infarct dementia disease or condition years Medical resulting in death) Due to (or as a consequence of): Examiner Cerebrovascular disease 5 years Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examin nding physician and use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Live Birth Pregnant at time of death for in the past 12 1 Yes 2XXNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension Completed 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Atrial fibrillation Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2XXNo 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Hospital 2XXNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 XX esidence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at al or Attending F s after death. I Director: After t 28d. Describe how injury occurred X Natural ...atural
Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours a Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title of certifier 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Redonda G. Miller, JHOC 7143, 601 N. Caroline Street, Baltimore, MD 21287 OCT 03 2012

30. Name and address of person who completed

egistrar's Signature

Registrar

D0047540

October 2, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10f, 18, 19a, b per fh 933 11-2-12 vt
State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8:00 P Physician/ WEISSMEYER SeMoth 30,2012 Jeanne Medical 4a. Facility Name (if not institution, give street and number)
Randolph Hills Nursing Home Examiner 4b. City, Town, or Location of Death 4c. County of Death
Montgomery Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days 577-30-9854 Washington, DC 1 M 2 F 85 Director Oct. 16, 1926 27 is merked other than "natural", or itama 23a or 28e-f shov traumetic event, tre Medical Examinar must be motified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Silver SPring MD Montgomery 1 Yes 2 No 10e. Street and Number 13211 Holdridge Rd. 10f. Zip Code 10g. Citizen of What Country? -20902-Funeral 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. White Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: should be filed within 72 hours after and Mental Hygiene.

Is merked other than "natural", If Yes. Give 3 ☐⟨Widowed 4 ☐ Divorced Specify Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Heal thcare Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည unknown Frank Steerman Berta Moses 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Adus (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If Itam 27 is any injury or other trau once. Claire Grossman, daughter PO Box <del>4514,</del> Woodbridge, VA 22194 20a. Method of Disposition ZUD. Place of Disposition (Name of cemetery, cramatory or other place)
King David Mem. Garden Oct.4, 2012 Falls Church, VA \( \bigcup \square \text{DBurial 2 } \bigcup \text{Cremation 3 } \bigcup \text{Removal from State 4 } \bigcup \text{Donation 5 } \bigcup \text{Other (Specify)} 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home Trubus 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Denentia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Cerebrovascular Disease Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of): ettanding physician end for usa es tha burlatzansit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day ate has baan signed by tha e page 2 should be detached t g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate in To the Funeral Director. After this certificate in the formplatally filled in by the funeral director, paging manual director, paging the funeral director. 1 ☐ Yes 2 ☐ No 25. Was case referred to medical å 26. Place of Death (Check only one) examiner? Hospital: Other: မူ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier neleer MD 10 D0064624 October 01, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VEIRS ROCKVILLE, MD 20850 9701 SANDEEP SHARMA 31. Date filed (Month, Day, Year) 22. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33785 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 20:350 2012 SEPTEMBER 26, MMARA Medical or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** OPKINS If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. 218-58-0199 **Director** 1 □ M 2 🗶 F May 23,1949 63 Yrs. MD 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 28a-f Salisbury 1 Yes 2 X No MD Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 1205 Flamingo Drive 21801 USA within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Black If Yes, Give Year or Dates 1 Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the n/a 12 Disabled other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ပ pe Goodsel Toadvine Naomi Dashiell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 8318 Rockmoor Ridge Rd., Charlotte, NC 28215 Christina M. Brown/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Calvary UMC Cem 10/06/2012 Fruitland, MD 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 21. Signature of Funeral Service Licensee 1618 West Rd., Salisbury, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nucvou stenosis Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ohysician and the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform page 2 this certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Yes ပ 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pendina 2 No To the Hospital or Attendi within 24 hours after death To the Funeral Director: A Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ppall MD

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Records,

**Division of Vital** 

State Registrar

32 Registrar's Signature 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

POON a M Pat CI MD / RA

Poon am

31. Date filed (Month, Day, Year)

ORIEMS St, BALTIMORE, MD 81287

SEPTEMBER 26, 2013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kathryn White October Pauline 0600 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisbury Rehabilitation allusing Ctr. 5. Social Security Number 6. Sex 17 Age Plans 194 France Wicomico Salisburg If Under If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Year Hours Director 220-26-4121 1 M 2 KF 81 08/22/1931 Delaware Usual Residence of Deced than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Salisbury 1 X Yes 2 No Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 USA 200 Civic Ave. death v 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces 1 Yes 2 No
If Yes, Give
Year or Dates. δ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Completed 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Laundry Presser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of Annie Marvel Lorenzo Morgan permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic s 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crystal Messick/Granddaughter 107 Louise Ave, Salisbury, MD 21804 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Acremation 3 Removal from State 10 4 2012 Salisbury Crematory Salisbury, MD 4 Donation 5 Other (Specify) OUTCO TO Licensee Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Chacamad 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Throselvotec disease or condition resulting in death) teros Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ဍ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Maymer of Death Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation М 1 Yes 2 No 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29d. Date signed (Mogith, Day, Year) 10 erson who completed cause of death (Item 23a) (Type, Print) Und 21884 Doroc Illistos State 32. Registrar's Signatur Registrar

12-07584 Elizabeth Ann W	late		e or Print in B						gible.		
Elizabeth Allii V		1- For State	ate of Maryland			i nealth f Death	id Meritai r		20	12 3378	
Physicia		Registrar  1. Decedent's Name (First, Middl	e,Last)		70010 0	, Bouin		2. Date of Deat	g. No.	3. Time of Death	
Medical Exami	ner	Elizabeth	n			Month October 6	Day Year , 2012	1612 hrs			
1		4a. Facility Name (if not institution	· ·			r Location of Dea	4c. County of Deat				
		Prince George's Hosp				Cheverly		Prince Georg			
Funeral Director		5. Social Security Number		ge (In yrs. last	If Under 1 Yes		in.	th(MM/DD/YYYY) 9. Bi Forei	gn		
Bilector		213-38-0401 1 M 2 X F 73 Yrs. 01/12/1939 Count								ountry) MD	
any		Usual Residence of Decedent  10a. State 10b. County	_	10c. City, To	wn or Loca	tion				10d. Inside City Limits	
br thow i	_	MD Char	les	Wal	dorf					1 ☐ Yes 2 ☒ No	
faryla:	Director	10e. Street and Number		<u> </u>		10f. Zip Code			Og. Citizen of What Cou		
Baltimore, MD 21215-0036  Separit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	ă	14638 Woodville Rd. 20601							Jnited St	ates	
h with	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S. If Yes, specify Cuban, Mexican, Puert							- 14. Race - Amer White, etc.	ican Indian, Black,	
r deat	F							o rasana story			
rs afte	ò	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify.  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of							Specify: Wh		
2 hour	ted	Elementary/Secondary (0-12)	College (1-4 or			nost of working life			TOD. KING OF BUSINESS	industry	
336 thin 7 than fedica	Completed	12		H	Iomen	aker			Own Home		
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	S	17. Father's Name (First, Middle,	Last)				18.Mother's Nan	ne (First, Middle, N	Maiden Surname)		
121   be fil   ental     rrked   vent,	Be	Philip Danie	1 Epp					a Mary Therres			
D 21 should and Me	2	19a. Informant's Name/Relations				- ,			ber, City or Town, State		
, MD and 2 sho ealth and em 27 is traumati	ŀ	Henry G. Wat	son/Spous	e 20b. Pla		8 Woods		Date	Ldorf, MD		
Baltimore, permit. Pages 1 an Department of He Important: If ite	ı	1 X Burial 2 Cremation	3 Removal from S	tate cre	matory or o	ther place)				·	
timent rtment rtant y or o	ļ	4 Donation 5 Other Sp 21. Signature of Funeral Service		St.	Mary	's Ch.	Cem 10	/12/12	Bryantow Funeral S	n, MD	
Ba Perm Depa Impe		1 1 0	91000	340 T E T	-7						
Physician	$\neg$	23a. Part I. Enter the disease, or	complications that cause	d the death. D	o not enter	the mode of dying	, such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval	
/Medical		failure. List only one cause Immediate Cause (Final disease	on each line. a. Multiple Injurie	s						Between Onset and Death	
Examiner		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions.  b.									
	<u>.</u>										
	틭	cause. Enter Underlying Cause (Disease or injury that initiated									
cuted and transit	Examiner	events resulting in death) Last Due to (or as a consequence of):									
	Cal										
60, ate be hysicial by buris		IF FEMALE:	23c. If yes, outco	ome of pregnar	ncy				23d. Date of deliver	<u> </u>	
587 ortifica ding pl	an/Med	23b. Was decedent pregnant in the past 12 months?	e 1 Live birth		2 F	etal death 3	Ectopic pregr	nancy		Day Year	
Box 68760, e death certificate be except the attending physician red for use as the burial.	Physici	1 Yes 2 No 9 Unk	nown 9 Unknown	at time of death	5 0	ther (Specify)					
Trhe d		1 Yes 2 <b>√</b>								the cause of death?	
b, P.O. ires that the signed by I be detach	d by									es 2 🗸 No 3 Probably 4 Unknown	
ords, w requir	Completed	24a. Was an autopsy prior to									
tal Records cian: The law requi certificate has been ector, page 2 should	틹							perfor	med? death?	completion of cause of	
tal Rician: Ticertifica	Be	25. Was case referred to medical				26.Plac	e of Death (Check				
Vita hysici this of	0	examiner? 1 ✓ Yes 2 No		ient 2 🗹 EF	R/Outpatien	t 3 DOA	Other Nurs	ing Home 5	Residence 6 Othe	r:	
n of Vi ding Physi After this funeral dir	Ţ.	27. Manner of Death  1 Natural 5 Page	28a. Date of In (Month Day Oct 6, 2012	jury 28 (Year) 1	3b. Time of 318 hrs		iry at Work?		ow injury occurred o involved in collis	sion	
ivisior or Attend after death Director:	cati	J Pend	tigation				Yes 2 ✔ No	10001 111111111111111111111111111111111			
Divi: pital or 2 ours after eral Dire filled in b	27. Walter of beath 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined Could not be determined (Specify) Major Road / Highway 250. Injury at votik?  1 Natural 5 Pending Investigation 250. Specify No Driver of auto involved 250. Driver of auto involved 250. Section from 1 July 250. Injury at votik?  1 Yes 2 No Driver of auto involved 250. Driver of auto involved 250. Driver of auto involved 250. Section from 1 July 250. Injury at votik?  1 Yes 2 No Driver of auto involved 250. Driver of										
Gospit Tospit Tuners		29a. Certifier	(-,,)	·			ate and place an				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
T wi	Me	29b. Signature and title of certifie	and manner stated	29c. License number				nth, Day, Year)			
		VM	1/	_		O.C.	M.E.		October 8, 2012		
10 m	ł	30. Name and address of person who completed cause of death (Item 23a)									
$O_{L_{i,i}}$		·	uty Chief Medical I				eet, Baltimore	e, MD 21223			
St Regist	ate trar	31. Date filed (Month, Day, Year) OCT 192	012 Zeenstr	ar's Signature	par						
1,69,5		771274	- Marie		_	<del> </del>					

DHMH 17 Rev 1/2001 OCME 2006

12-07557 Raymond Hoster	tlar '	Please Type or Print in Black Ind					0 0070			
rayinona moste		1- For State Certif	ificate of D			201	2 3378			
Physicia	-	Registrar  1. Decedent's Name (First, Middle,Last)	neate of D		2. Date of Dea	eg. No. th	3. Time of Death			
Medical Examiner		Raymond Hostetler	Yoder		Month October 5	Day Year . 2012	1945 hrs			
		4a. Facility Name (if not institution, give street and number)		City, Town, or Location						
	strik e singwebe	Dubois Rd. / Trinity Lake	D	entsville		Charles				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	_	Under 1 Year If Under 1 Year I	ro Mio	th(MM/DD/YYYY) 9. Bi	thplace (State or			
Director		212-57-3069   1XM 2 F   30	Yrs.	Jayo Haa	06/28	/1982 cd	ountry) Maryland			
any	ŀ	Usual Residence of Decedent  10a. State 10b. County 10c. City, To	own or Location				10d. Inside City Limits			
▶ .		Maryland Charles Me	ahani aa	rrillo			1 Yes 2 X No			
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number	chanics	of. Zip Code	[1	0g. Citizen of What Cou	ntry?			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	盲	9443 North Ryceville Road		20659		USA				
n with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.			igin? ( Specify Yes or No	- 14. Race - Amer	ican Indian, Black,			
or ite	Ē	1 Yes 2 X No	l	specify Cuban, Mexica		White, etc.				
s after	ত্র	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 1:		s 2 X No specif			White			
2 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		Isual Occupation (Given of working life, DO NO		16b. Kind of Business/	Industry			
5-0036 iled within 7/Hygiene.	흴	12		Furniture						
5-00 ed wi tygier other	3	17. Father's Name (First, Middle, Last)		penter 18.Moth	er's Name (First, Middle, M					
21   be fill   ontal F	å	Manasse A. Yoder		Fr	aney A.	Hostetle	r			
D 21 should and Me 7 is ma	입	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Ad	dress (Street and No	mber or Rural Route Num	nber, City or Town, State	e, Zip Code) 20659			
mnd 2 and 2 ealth a		Emma G. Yoder/Wife  20a. Method of Disposition 20b. Pla		Orth Rycev (Name of cemetery,	ille Rd., Me	echanicsvil 20c. Location - City or				
Baltimore, permit. Pages l a Department of He Important: If ite		1 X Burial 2 Cremation 3 Removal from State cre	ematory or other p	place)						
ti. Pa		4 Donation 5 Other Specify: He 1 21 Sign Superal Section Light name	rtzler (		10/8/2012		ville, MD			
Ba Perm Depa Impo	1	David A. Got	ff Mat	tingley-Ga	rdiner Fune	ral Home, H	P.A.			
Physician		23 Par I. Enter the isea of occupications that caused the death. D	o not enter the m	ode of dying, such as	St., Leona cardiac or respiratory arre	est, shock, or heart	Approximate Interval			
/Medical Examiner		failure. List only one death line.  Immediate Calle (Final disease a. Drowning					Between Onset and Death			
ZAAIIIIIei		or condition resulting in death) Due to (or as a consequence of):								
	<u>-</u>	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):								
	i i	cause. Enter Underlying Cause (Disease or injury that initiated								
ed .	Examiner	events resulting in death) Last Due to (or as a consequence of):								
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	<u>Sa</u>	d. UNPENDED AMENDED								
60, ate be hysici e buri	Med	IF FEMALE: 23c. If yes, outcome of pregnar	ncv			23d. Date of delivery	,			
687 ertifica ding p	sician/Med	23b. Was decedent pregnant in the past 12 months?	2 Fetal d	eath 3 Ectop	ic pregnancy		Day Year			
OX (eath ce atth ce attence for use	Sici	Yes 2 No 9 Unknown Pregnant at time of death	1 5 Other	(Specify)		1	Į			
rthe d	Phy	Part II. Other significant conditions contributing to death but not resu	ulting in the under	rlying cause given in F	Part I. 23e. Did to	bacco use contribute to	the cause of death?			
tal Records, P.O. cian: The law requires that th certificate has been signed by ector, page 2 should be detach	d b				1 Yes	2 V No 3 Prot	pably 4 Unknown			
Division of Vital Records, ral or Attending Physician: The law require rs after death.  al Director: After this certificate has been side the funeral director, page 2 should be the funeral director, page 2 should be the funeral director.	Completed				24a. Was a		topsy findings available completion of cause of			
eco he law te has	Ĕ	autopsy performed?    autopsy performed?   1   Yes 2   ✓ No 1   1								
Vital Rec ysician: The his certificate director, page		25. Was case referred to medical	<del> </del>	26.Place of Deatl	(Check only one)	2 ✓ No 1 Ye	es 2 No			
Vit;	To Be	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 Ef	R/Outpatient 3	DOA Other	Nursing Home 5	Residence 6 🗸 Other	: Scene			
J of Jing Ph		1 Notural (Month Day, Year)	8b. Time of Injury		وروحان المراجعة والمراجعة	now injury occurred	-			
SiOn Attend death. ctor:	lăt Iğ	2 Accident Investigation	700 hrs	1 Yes 2 ₩	No					
Divis pital or At ours after d eral Direc filled in by	ertification:	3 Suicide 6 Could not be determined (Specify) Lake	e, farm, street, fa	ctory, office building, e	or Town, S	Street and Number or Ru tate)	100			
Cospita hours uneral	O	4 Homicide Getermined (Specify) Lake Dubois Road / Trínity Lake, Dentsville, MD								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the built	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.  29b. Signature and title of certifier  29d. Date signed (Month. Day)									
To with	Mec	and manner stated.  29b. Signature and title of certifier		29c. License numbe		29d. Date signed (Mo				
(A)		0 000		O.C.M.E.		October 6, 2012				
	-  -	30. Name and address of person who completed cause of death (Item 23	3a)			<u> </u>				
5		Jack Titus Mb. Deputy Chief Medical Examiner	900 W. Balt	imore Street, Ba	timore, MD 21223					
	ate	31. Date filed (Month, Day, Year) 2012 32. egistrar's Signatur	park	7						
Regist	ııı	001 = 0 = 012	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2045 MSO a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Secours HOSDIta Bal MD 6 Sex **Funeral** If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Min. Hours Director **№** M 2 🗆 F 214-54-6088 62 SEPT 21 1950 MD Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD BALTIMORE 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code injury or other traumatic event, the Medical Examiner must be 10g. Citizen of What Country? Funeral 2818 EVERGREEN AVENUE 21214 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc 0 ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Hygiene. If Yes, Give Year or Dates. 1 Yes 2X No Specify: 3 Widowed 4 Divorced Completed Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) TRANSPORTATION AIDE SINAI HOSPITAL marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ FRANK ADAMSON, JR. MILDRED SIMMONS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2: DOROTHY HOLLEY - SISTER 2818 EVERGREEN AVE. BALTO., MD 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 💢 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) On-Site 10/17/12 Baltimore, Md 21. Si e of Funeral Service License 22. Name and Address of Facility any 4300 WABASH AVE. MARCH FUNERAL HOME WEST, INC. BALTO. MD 21215 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of) nding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Ectopic pregnancy Pregnant at time of death Month Day 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, Completed 1 ☐ Yes 2 1 ☐ Yes 2 1 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 Yes Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 10 Hospital 1 🗌 Yes npatient 2 ER/Outpatient 3 DOA Other: this 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? within 24 hours after death. To the Funeral Director: After 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

2 Doo W.
31. Date filed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

(2

Michael Doff

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible link. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Year Day Month 3:40A Physician/ Elsie L. Brauning Oct 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Mt. Airy Lorien Nursing Home If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Davs 213-05-3843 Director 1 □ M 2 🗗 F 2-14-1917 MD 10d. Inside City Limits show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location irector 1 🗌 Yes 2 🗷 No Carroll Sykesville MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21784 Funeral 3724 London Bridge Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: white 1 Yes 2 No Specify. 3 ☐₩idowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Caroline Bitzel William Barber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26100 Cornor Dr., Damascus, MD 20872 Charles A. Brauning-son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 10/23/2012 Finksburg, MD 4 Donation 5 Other (Specify) Evergreen Mem 22. Name and Address of Facility Fletcher Funeral & Cremation 21. Signatura of Juneral Service Licensee 254 E. Main St., Westminster, MD 21157 (7) romas tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Part 1. Enter the disease, or complice shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ theroscleratio Coronari disease or condition resulting in death) Medical <sup>4</sup>Examiner 2005 Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed at house after aleath within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last as a consequence of 2006 Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 2 1 No 1 Tes 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other: 2 1 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 22 12 radiu 115117 10 mal 01157 mol State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 12, 20**1**2 Nancy Bronner 7:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5912 Saint Moritz Drive #202 Temple Hills Prince George's Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Months 12/29/1954 577-72-8640 **Director** 1 🗆 M 2 🔀 F Washington, DC show 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director or 28a-f sh notified 1 Yes 2XXNo Maryland Prince George's Temple Hills 10e. Street and Number "natural", or items 23a or edical Examiner must be n 10g. Citizen of What Country? and 2 should be filed within 72 hours after death with I Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a Funeral 20748 USA 5912 Saint Moritz Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. 1 Yes 2 If Yes, Give Year or Dates. 1 Never Married 2 Married Š Baltimore, Maryland 21215-0036 1 Yes 2x XNo Specify: Black 3 Widowed 4 XXDivorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) r than ". Elementary/Secondary (0-12) 12 College (1-4 or 5+) DISABLED 27 is marked other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Nabinett Dorothy Helen Hough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Ingram / Son Briarview Ct. Severn, Maryland item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of I Important: If it any injury or or once. cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Kivardala 4 Donation 5 Other (Spec) Rivordale 10-22-21. Signature of Funer McLaughlin e. SE Wash. 2518 Penn. Ave. 23a. Part 1. Enter the disease, or shock, or heart failure. List e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, emplications that caused y one cause on each line Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) resulting in death) Last physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? Month Day Pregnant at time of death Yes 2 X No Unknown 9 Unknown should be detact signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 1 Yes 2 No Yes funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5XX Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XXNatural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ours after death.

Jeral Director: Af Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier 1 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of persons

31. Date filed (Month, Day, Year)

Emmanuel

Southand

WAShing

20032

completed cause of death (Item 23a) (Type, Print)

1328

Brown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 12:18 PM S. Burrell OCTOBER 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SINAI BALTIMORE HOSPITAL OF BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Director 1 M 2 D F 213-30-3826 78 34 02 28a-f show 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Modical Examinar must be notfling at with the Maryland 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 ☐ No NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 U.S.A. 4217 Fernhill 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Sylvester Black, White, etc. 1 Never Married 2 Married Completed by 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene important: If item 27 is marked other than any injury or other traumatic event, the Magnes, once. Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade Cab Driver Cab Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည BURRELL, GARL Dorothy Nash Page 1 and 2 should be Dewight Burrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fernhill Ave, Baltimore, Md 21215 Barbara Burrell 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 10/18/201 Baltimore, 21. Signature of Funeral Service Licenses 2. Name and Address of Facility
March F/H West 4300 Wabash Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Opset and Death Immediate Cause (Final SMALL Pnysician/ disease or condition resulting in death) NON-Medical Due to (or as a consequence of): Examiner ESPIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 St Other (Specify) မ 1 Tyes 2 🔀 No HOSPICE 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one 29b. Signator and title of certifie 29d. Date signed (Month, Day, Year) KES 000 OCTOBER 17, 2012 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD SINAL KALTIMORE 2401 W. BELVEDERE GOSAIN HOSPITAL OF

DHMH 17 Rev 06-2011

State

Registrar

2:-:1 =

22

31. Date filed (Month, Day, Year)

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** HANLOTTE 1224 A 10 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rosedale FRANKLIN Saucite HOSPITal Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral Days 1 □ M 2 🖾 F 79 Yrs. 215-32-8365 Director 07/07/1933 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f sho Injury or other traumatic event, the Medical Evant has must be natified at Baltimore Glen Arm 1 □Yes 2X No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with USA 21057 5519 E.Glen Arm Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Custodian 12th grade land 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Robert Cook Bessie Elizabeth Polston Baltimore, Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 19a. Informant's Name/Relationship (Type, Print) item 27 i Cory L.Johnson 8903 Waltham Woods Rd.Apt. E.Parkville MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iten
any Injury or ott 10/289/12 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt.Zion A.M.E.Church Cemetery Glen Arm, MD. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Chatman-Harris Funeral 21. Signature of Funeral Service Licensee 4210 Belair Rd.Baltimore Maryland 21206 Cull 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prosable SUDDEN CONSIDE DEATH SUNDHONG **Physician** /Medical Due to (or as a consequence of): Examiner unmonany Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine CHOSPACH NEWA OISTAKE attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No
9 □ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No certificate 1 ☐ Yes 2 Me No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 🏋 ER/Outpatient 3 ☐ DOA 1 Yes 2 No မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 filled in by the f within 24 hours a To the Funeral L

アクトト

00

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S21-N. GUMWST.

D006 4555

SWITE 308

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

10-15-2017

Arthurit

Iony warestest 31. Date filed (Month, Day, OCT 2 2 2012

29b. Signature and title of certifier

4 Homicide

29a, Certifier

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ COPPAGE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death MEMORIAL BALTIMORE UNION HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) 213-06-1230 **Director** 1 □ M 2 XF MD -05-Usual Residence of Decedent or 28a-f show 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified MD1 Yes 2 ☐ No BAUTIMORE 10e. Street and Number 10g. Citizen of What Country? be ms 23a Funeral RENDAN HVENUE 21213 USA "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced 4 Divorced Specify: BLACK Completed Year or Dates 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) PersonAr RAINER DHA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Henry reasan Ernestin 19a Informan's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Md. 21213 w 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛮 Burial 2 🗌 Cremation 3 🗆 Removal from State cemetery, crematory or other place, KING Memorias Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) 10-26-12 21. Signatur of Funer II Service Licensee 22. Name and Address of Facility VAUEHN GREENE FUNERAL SUS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Retween 2nd Death Immediate Cause (Final Physician/ Trucere hol disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to him rediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or injury that initiated events resulting in death) Last use as the burial-trar Due to (or as a consequence of): attending physician of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy eral Director: After this certificate has been signed by the atte filled in by the funeral director, page 2 should be detached for Month Day Pregnant at time of death g 🗌 Unknown 9 Unknown ng cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underly 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requirement 24 hours after death.

To the Funeral Director: After this certificate has been seempletely filled in by the funeral nicertor. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to cal Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Matural 5 Pending Division 1 Yes 2 \ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and life 0, 30. Name and address of person who completed cause or death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed-(Month, Day-Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 9932 10-22-12 vt. State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death Registra Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Year Esther Chainey М Medical 2012 00a 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 3919 Cedardale Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday Funeral 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Days Hours Min 217-16-5059 Director 1 M 2 X 06 17 18 MD 94 Usual Residence of Decedent show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location within 72 hours efter death with the Maryland 10d. Inside City Limits rector Y Yes 2 No NA Baltimore ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 U.S.A. 3919 Cedardale Road 12. Was Decedent Ever în U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ۾ 1 Yes 2 No If Yes, Give Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. Black Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+ 4th grade Housewife Home na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 Bertha Johnson Pe Peter Spicer traumatic 1 and 2 should be of Health and Mer Item 27 Is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3402 Virginia Ave, Baltimore, Md 21215 19a. Informant's Name/Relationship (Type, Print) Carlita V. Mines-Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Department of H Importent: If Its eny Injury or of once. 1X Burial 2 Cremation 3 Removal from State Garrison Forest Vet 10/29/12 Owings Mills, 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig a u of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyi shock, or head failure. List only one cause on each line. such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final £nysician/ MYUMIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events euren Examine Due to (or as a consequence oi). burial-transit and Due to (or as a consequence of): resulting in death) Last the attending physician Physiclan/Medical The law requires that the death certificate be Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) detached g Unknown g Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ě, 1 Yes 2 No 3 Probably 4 Unknown been sign Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No • Hospital or Attending Physician: 24 hours after death.
• Funeral Director: After this certificately filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 🗹 No 1 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 06-2011

State

OV

To the Hosp within 24 hou To the Funer completely fi

29a Certifier

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOFTENS 2411 W. BELVEN EXE

32. Registrar's Signature

2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

4626

AVE. BALTIMOR MID

29d. Date signed (Month, Day, Year)

20/2

29c. License number

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

		1	For State		St	tate of M	larylan					and M	1ental Hy	_	012	) (	33796
			1 - State Registrar Certificate of Death  1. Decedent's Name (First, Middle, Last)  2. Date of Death										.014				
Ar a	Physicia Medic		John Will											Month 19 <sup>ay</sup> 20 <sup>Yea</sup>			Time of Death 2:50 P M
	Examin	er	4a. Facility Name (if r Kline Hos		_	and number)				Town, or Location of Death  Airy				4c. C Fre			
	Funeral Director		5. Social Security Nu 213–24–72		6. Sex	7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.					8. Date of Bird (Month, Da		Birthplace (State or Foreign Country)				
		ž	Usual Residence of 10a. State	Decedent  10b. County			82	Yrs.	cation				12/22/	1929	MD	I 10d Jr	nside City Limits
	Maryla 28a-f s otified	Director	MD	Carro:	L1			Airy									Yes 2 No
	with the	Funeral D	304 Carro						10f. Zip	771				-	en of What Co	,	
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once,	þ	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed 4		ed 1	12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates. Korea			If Yes, specify Cuban, Mexican, Puert			n, Puerto I				e - American Indian, k, White, etc. <b>White</b>	
215-(	72 hou an "natu Medica	Completed		15. Deceden	t grade cor	npleted)		16a. Deced (Give H	lent's Usua aind of wor O NOT use	k done du		st of workin	ng	16b. Kind	d of Business	/Industry	ý
1212	d withir fygiene. ther the nt, the I	0	Elementary/Secor			ollege (1-4 or t	5+)	Princ						_		Pub l	lic Sch.
ylanc	d be file Mental H arked o	To E	Harold The									ner's Name La Bor	(First, Middle, 1 <b>e</b>	Maiden Sui	rname)		
Baltimore, Maryland 21215-0036	nd 2 shoul ealth and n n 27 is m		19a. Informant's Nar <b>Juanita</b> M			int)					and Number or Rural Route Nu						
more	Page 1 arent of He ent of He nt: If iter		20a. Method of Dispo 1 X Burial 2 C 4 Donation	Cremation		val from State	ce	ace of Disposemetery, crem	natory or o	ther place,			ate +/2012		ation - City or		
Baltin	permit. F Departm Importa any inju		21. Signature of Fund			0	<u> U</u> TT	lcrest bu	. Name an	d Address	of Facili	<sub>ty</sub> unera	1 Home	and	erland Cremat	ory,	. P.A.
			23a. Part 1. Enter the shock, or heart	failure, List or	complication ly one caus	ns that caused se on each line	d the death		LZ_W	$-v_{\perp u}$	1411/	ELLY	MI WI	IIITET	d, MD	Appi	34 roximate val Between
,e	Ph_sician/ / Medical		Immediate Cause (F disease or condition resulting in death)		a. —	Due to (or as	a conseque	T/C	Pa	LIR	R					MON 7	et and Death
	Examiner	er	Sequentially list con-	ditions,	b. —	C Lue to for as	IRRH	15515	D &	C L.	IVE	R				mon	THS TOYEAR
	outed nd transit	Examiner	Sequentially list con- ir any, leading to inn- cause. Enter Underly Cause (Disease or in that initiated events	ving ijury	c	Due to for as	a conseque	snice ory.									
,60	icate be executed physician and is the burial-transit	edical E	resulting in death) La	ast	d	Due to (or as	a conseque	ence of):									
6876	ertificate ding phy se as the	/Med	IF FEMALE:		220 16	una autaama	of prosection										
Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	by Physician/M	23b. Was decedent p in the past 12 m 1  Yes 2  9 Unknown	onths?	1 4	yes, outcome ☐ Live Birth ☐ Pregnant a ☐ Unknown	2 Fetal	death 3	Ectopic p Other (spe					230	d. Date of de Month	livery Day	Year
ls, P.C	ires that 1 signed b										n in Part	1.					se of death?
corc	law requ has beer e 2 shou	Completed											24a. Was a	sy	prior to	topsy fin	ndings available ion of cause of
al Re	s <b>ician:</b> The law is certificate has the last th		25. Was case referred	I to medical	1					26. Plac	e of Dea	th (Check	1 Yes	med? 2 No	death?	3 2 🗗	No
f Vit	Physici this ce	유	examiner? 1 Yes 2 2	No	Hospita	al: 1		R/Outpatien		A Other:	4 □ Nι	ursing Hon	ne 5 🗆 Resid			ify HOS	PICE HOUSE
o uo	ending eath. or: After the fune	Certificate:	1 Natural 2 Accident	5 Pending	ation	(Month, Day	, Year)	injury	М (28	Bc. Injury a work? 1 \(\sum Ye	es 2 🗆		8d. Describe h	ow injury oc	ccurred		
Divisi	al or Att s after d l Direct	Certi	3 ☐ Sulcide 4 ☐ Homicide	6 Could no determin		e. Place of Inju building, etc	ry - At hon c. (Specify)	ne, farm, stre	et, factory,	office		2	8f. Location (S City or Town		umber or Ru	ral Route	e Number,
	ne Hospit n 24 hour ne Funera	Medical	(Uneck 2 L	⊒ Medicai⊑x	aminer: On	the basis of e	xamination :	and/or investi	gation, in m	iv opinion.	. death or	ccurred at t	d due to the ca he time, date ar e, and due to th	nd place an	d due to the o	cause(s) s	and manner stated.
	To th within To th		29b. Signature and the	of certifier	1//	// _			29c.	License n	umber	_		29d. Date s	igned (Month	n, Day, Ye	ear)
Q	XI		30. Name and addres ROnald E.	s of person w	no complete	ed cause of de	eath (Item 2	23a) (Type, Pr Dr. Mt	int)					10.	- 22-	12	
	Stat	_	31. Date filed (Month,	Day, Year)	- : : 1	32 Amintra	er's Signatu	ra									
į.	Registra	r	()(	722	2012	Cham		fa	Mar								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#7perFH, G932, 10/22/2012, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 945 AM HARRIET DUBANSKY 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE N/A LEVINDALE HEBREW HOME If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Social Security Number 7. Age (In vrs. last birthday **Funeral Director** 213-18-2271 1 □ M 2 **X** F -88 02/08/1921 MD Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State Director 1 Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 1700 WOODHOLME AVENUE 21208 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 X Widowed 4 □ Divorced Completed WHITE Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 h and Mental Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, UNKNOWN HYMAN SILVER LENA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a ROBERT DUBANSKY/SON 2 WHISPERWOOD COURT, BALTIMORE, MD 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o ARLINGTON CEMETERY CHIZUK AMUNO CONG. 1 X Burial 2 Cremation 3 Removal from State 10/19/2012 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Loren ye SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 3 Mouth Immediate Cause (Final FAILUNG THRIVE Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examine Due to (or as a consequence of) burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last physician a P.O. Box 68760 < Physician/Medical as IF FEMALE: ISe 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? atter for Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2's 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MALNUTRITION 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 Tyes Decubitus vicers - multiple 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 CENEBRO VASCULAR performe death? certificate Yes 2 V 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ပ funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6  $\square$  Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 030377 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARK HEIGHTS AVE BALTIMORE MD 21215 COOPIER MY m. 6503 31. Date filed (Month, Day, Year) 32. Registar's Signature State OCT 2 2 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Tina Dass Month 9:00 P M OCTOBER 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Randallstown Northwest Hospital Center **Baltimore** 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Director 217-06-0858 1 M 2 X F 44 1968 Maryland 1, . Page 1 and 2 should be filed within 72 hours efter death with the Maryland ment of Health end Mental Hygiene. Fent: if Item 27 is markad other then "netural", or Items 23e or 28e-f show lury or other treumatic event, the Medical Examinar must be notified at 10h County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Severn 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21144 302 Fairfield Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Specify: Completed White Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Homeowner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ం Marlow Syrup Betty Stevenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Patrick Ryan/ Son <u> 2000 E. Tamarack Road, Apt 407, Altus, OK 73521</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of importent: if it eny injury or o 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, Maryland Metro Crematory 10/20/2012 21. Signature of Funeral Service Censee 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Highway SE, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 4 rethral ancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): nding physician end use as tha burial-transit Cause (Disease or injury that initiated events Hospital or Attending Physician: The lew requires that tha death certificete be executed Due to (or as a consequence of): resulting in death) Last within 24 hours after death.

To the Funeral Diractor: After this certificate has been signad by the attending physician completely filled in by the funeral director, page 2 should be detached for use as tha buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dottler Specify Pent has pile မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) nsRijapidnemp D0057465 10/17/17

State Registrar 31. Date filed (Month, Day, Year)

5203

Balomore MD 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NSIMPAKSEMD 2835 5 m 1 Th

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ UREEN Month FOOTE 2012 20 10:55 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOSPICE CENTER BALTIMORE TOWSON If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 DM 2 1 **Director** MARYIAND 124 10c. City, Town or Location 10a State 10b. County ir then "naturel", or itsms 23e or 28s-f sho the Medical Examiner must be notified at 10d. Inside City Limits **Funeral Director** 1 Yes 2 □ No MD BALTIMORE 10e. Street and Number 10g. Citizen of What Country? SPAULDING U.S.A. 21215 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed Specify: BLACK 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other then Elementary/Secondary (0-12) College (1-4 or 5+) KEEPER House HOME MAKER ıa 27 is marked oths traumatic svent, æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname end Mantel ၉ CLARENCE EDWARD MAITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/2/5 Health SON WAYNE E. FOOTE AVE. BALTIMORE MARYIAND 20a. Method of Disposition
1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Department Importsnt: if any injury or once, BALTIMORE, MARY LAND 2012 METRO CREMATORY INC 4 Donation 5 Other (Specify) 22. Name and Address of Factoria DERRICK C. JONES FIH, P.A. 21. Signature of Funeral Service License 14675. AVE, BALTIMORE, MARY pond C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Certificate: To Be Completed by Physician/Medical Examiner Due to (or as a consequence of) anding physicien and use as the burlel-trens Due to (or as a consequence of): Box 68760 attending I IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) After this certificate has bean signed by the a funarel director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funerel Director: Af completely filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ony one) D007128= ss of person who completed cause of death (Item 23a) (Type, Print) 10 70 31. Date filed (Month, Day, Year, State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1<sup>Month</sup> Day 201<sup>Y2</sup> 16 7:30P Agnes Flight Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death N/A**Examiner** Baltimore 812 W. Lexington St. Apt 10 . Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 216-22-4599 Director 1 M 2 KD F 09/16/1927 Virginia 85 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Eventium must be notified at any injury or other traumatic event, the Medical Eventium must be notified at agines. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director N/ABaltimore 1 X Yes 2 No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 21201 812 W. Lexington St. Apt 10 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🗓 No If Yes, Give 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black 3 N Widowed 4 Divorced it yes, Give Year or Dates Completed 15. Decedent's Education 16a. Decedent's Usual Occupation Ba Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools Cafeteria Worker 9th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Olivia Walker Thomas Jackson Code) 21201 19a. Informant's Name/Relationship (Type, Print) Address (Street and Number or Rural Route Number, City or Town, State, Zjp Code) W. Lexington St. Apt 10, Balto., Agnes Medley(daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 10/22/12 Mt. Zion Cem. Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 27 by gershid of or Barby wn Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transif Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) To the Hospital or Attending Physician: The law requires that the dear within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the arcompletely filled in by the funeral director, page 2 should be detached formpletely filled in by the funeral director, page 2 should be detached for the funeral director. 9 Unknown 9 Unknow P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy 1 ☐ Yes 2 ☐ No æ 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 ☐ Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5830 OCTOSION

State Registrar s of person who completed cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of I	Marylan		artment of tificate of		and M		giene Reg. No. 2	)   2	33801		
	Physicia		Decedent's Name (First     ROBERT FR	,			-				2. Date of De Month	Day	Year	3. Time of Death		
- Tong	Medi Examir		4a. Facility Name (if not in:		treet and number	)		4b. City, Town,	or Location	of Death	10	4c. County	2012 of Death	6:00 A M		
-A	f		FUTURE CA			1T			TIMOF	RE		BALTIMORE				
	Funeral Director		5. Social Security Number  214-68-880  Usual Residence of Dece	7 1 Gedent	x 2 □ F	Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Yea Months Days		r 24 Hrs. Mın.	8. Date of Bir (Month, Da 8 / 1 2		9. Birthpl Counti MD	ace (State or Foreign y)		
	ne Maryland or 28a-f show notified at	to		County			y, Town or Loc						10	d. Inside City Limits		
	r 28a notifii	Director	MD BA	LTIMO	RE	BA	LTIMO:	RE 10f, Zip Code						1 Tes 2 No		
	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	Funeral	1046 OLD	NORTH	POINT F	ROAD		212	2.4			10g. Citizen of	What Count	ry?		
	death items ier mi	표	11. Marital Status		12. Was Deceden Armed Forces		S. 13. V	vas Decedent of Yes, specify Cul		igin? (Spec	cify Yes or No-	14. Rac	e - America			
36	after (	Completed by	1 X Never Married 2 3 ☐ Widowed 4 ☐ D		1 ☐ Yes 2X If Yes, Give	No		Yes 2 XN			Rican, etc.)		ck, White, et BLAC			
21215-0036	hours natura lical E	lete	15. [	ecedent's Edu	Year or Dates.			ent's Usual Occi				16b. Kind of B				
218	nin 72 ne. han "i e Med	omp	(Specify on Elementary/Secondary	ly highest grad (0-12)	e completed) College (1-4 o	r 5+)	(Give k life. DC	ind of work done  NOT use retired	during mos	st of workin	ng	TOD. KING OF B	usiness/ing	ustry		
72	dygier Hygier Ither t	Be C	UNK 17. Father's Name (First, N	liddle Leet)	UNK.		UNI	KNOWN	Τ			OWNKI				
Maryland	be filk ental l rked o rc eve	To	Tr. Father's Name (First, IV		NKNOWN				18. Moth		(First, Middle, UNKNO)	Maiden Sumam NN	e)			
lary	1 and 2 should be if Health and Meritem 27 is marke other traumatic		19a. Informant's Name/Re	lationship (Type	e, Print)		19b. Mailin	g Address (Stree	t and Numb			r, City or Town, S	State, Zip Co	ode)		
	and 2 Health em 27		ARTHUR DR 20a. Method of Disposition		- GUARD				ERT S			LTIMORI				
Baltimore,	or if		1 🗔 Burial 2 🗌 Crei	mation 3 🗆 R	Removal from Star	te 20b. P	emetery, crem	sition (Name of atory or other pla			ate	20c. Location	- City or Tov	n, State		
altir	4. もぞき		4 Donation 5 0	Other (Specify)  Prvice Licenses	9	MT		<b>4EL</b> Name and Addr			7/12	BALTI				
Ä	Depar Impo any ir		ful /	Skl	- mo	1120				תכ	, BAL	FUNERAI FIMORE	J HOM MD 2	E 1224		
	Physician/ Medical Examiner	ner	23a. Part 1. Enter the dise shock, or heart failure Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition if any, reading to immediate	a. List only one	Due to (or as	s a consequ	ence of):	the mode of dy				ine Bu		Approximate nterval Between Donset and Death		
200	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	C d	Due to (or as	s a consequ	ence of):									
). Box 68760	requires that the death certificat been signed by the attending ph should be detached for use as th		IF FEMALE: 23b. Was decedent pregna in the past 12 months 1  Yes 2 No 9 Unknown	110	3c. If yes, outcom 1  Live Birth 4  Pregnant 9  Unknown	2 Fetal at time of de	death 3 🗌	Ectopic pregnar Other (specify)	ncy			23d. Da Mo	te of deliver	y Yay Year		
Division of Vital Records, P.O.	law requires that has been signed t e 2 should be det	Completed by P	Part II. Other significant of Schipe Faul a	onditions cont	tributing to death	but not resu	alting in the ur	derlying cause g	Jash fo	i.	1 🔲 Y	an 24b.\	3 Proba	cause of death?  bly 4 Unknown  y findings available oletion of cause of		
E E	sician: The law r		25. Was case referred to m	adiast .							perfor	med? of	death?	X No		
Vita	ysicial s certi directo	To Be	examiner?		ospital:	tient 2 🗆 🗆	ER/Outpatient	Ott	Place of Dea			<u> </u>	(0)			
of	ng Phy fter thi ineral		27. Manner of Death	Pending	28a. Date of inj	ury :	28b. Time of injury	28c. Inju	ry at	ı		ence 6 Othe ow injury occurre				
ion	tendii death. tor: Ai the fu	Certificate:	2 Accident	nvestigation Could not be				M 1 🗆	Yes 2	No						
)ivis	al or Ai s after I Direc d in by			determined	28e. Place of In building, e	jury - At hon tc. <i>(Specify)</i>	ne, farm, stree	et, factory, office		21	8f. Location (S. City or Town	treet and Numbe n, State)	er or Rural R	oute Number,		
_	ne Hospitz n 24 hours ne Funeral pletely fille	Medical	(Check 2 L Me	dical Examine	ian: To the best or: On the basis of Practitioner: To t	examination	and/or investig	nation, in my onin	ion, death or	curred at the	ne time date ar	id place, and due	to the cause	(s) and manner stated		
	To the within the complete com	— r	29b. Signature and title of c				,	29c. Licens		1521		29d. Date signed	(Month, Da	y, Year)		
			30. Name and address of p	erson who com		death (Item 2	23a) (Type, Pri	Ral O	SLVD	. N	l.D	21221				
	Stat Registra	G	31. Date filed (Month, Day,	(ear)	320Regist	rar's Signatu	par	Kel								
			<del>- UG1 </del>	6 % CU14	MANNE	and he	7									

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Year 1803 Charlie Gallop 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George howarly 9. Birthplace (State or Foreign Country) Hospital Age (In yrs. last birthday. 8. Date of Birth (Month, Day, Year) Funeral 24 Hrs. Min. Days Hours 227-58-814 **Director** 1 X M 2 □ F Chesapeake VA 67 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 No Capitol 10f. Zip Code Prince George M.D 10a. Citizen of What Country? Funeral US 6104 Add Ison 20743 death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Completed by 1 Never Married 2 Married 72 hours after XYes Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Black "natural", 3 Divorced 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be me and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) DC Police Dept Detective <u>12th</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanley Hilliard Gallop Lena Turner Battes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Clara Gallop/Wife Addison Rd, Seat Pleasant MD 20743 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Oct 20, Chesapeake, VA Cemetery 2012 21. Signature of Funeral Service Li DL McLaughlin Funeral CC0257 Penn Ave, SE Wash. DC 2518 23a. Part 1. Enter the disease, or considerate shock, or heart failure. List only one constant ications that caused the death ne course on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed burial-trai Due to (or as a consequence of): physician s the buria Physician/Medical Box 68760 anding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months?
1 Yes 2 No Day Month Year the Unknown 9 Unknown P.O. signed by to d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Hospital or Attending Physician: The law requires Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performe death? 2 🗌 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 **X** No Hospital Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral nours after death.

neral Director: After th
filled in by the funeral 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Frantitioner: To the best of my k 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year)

Registrar

DHMH 17 Rev 06-2011

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 <sup>Day</sup> Marshall Green 20<sup>rear</sup>2 5:10a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice N/A Social Security Number If Under 1 Year If Under 24 Hrs. 7 Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days (Month, Day, Year) Hours 213-34-3772 77 Director 1 X M 2 - F MD 06/6/1935 Usual Residence of Decedent r than "natural", or items 23a or 28e-f show the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore MD 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 1812 Burnwood Road USA death v 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) 2\( \text{No} \) No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pege 1 end 2 should be filed within 72 hours efter Department of Heelth and Mentel Hygiene. Importent: If item 27 is marked other than "natural", or eny injury or other treumatic event, the Medical Examir ģ 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) UNK Stock Clerk UNK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joshua Green Mary Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1812 Burnwood Rd. Baltimore, MD 21239 <u>Debra Wa</u>llace 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 23/12 10 On-Site Crematory Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Leensee <sup>22.</sup>Name and Address of Facility own Jr. Funeral Home Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD PA 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Closmizion disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed attending physician end I for use es the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death sate has been signed by the apage 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 □ Probabiy 4 □ Unknown 1 🗌 Yes Were autopsy findings available pnor to completion of cause of 24a. Was an autopsy perform death? 24 hours after death.

Funeral Director: After this certificate letely filled in by the funeral director, pag 1 Yes 2 🗌 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) hospic 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death usparited at the time, date and place, and due to the causa(s) and member as state 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMON HARVES Charles MO 6701 31. Date filed (Month, Day, Year) 32. Recistrar' OCT 22 Registrar

DHMH 17 Rev 06-2011

12-07862	_	Please Type or Print in Black Indelible Ink. Ensure  State of Maryland / Department of Health and	Montal Hy	s Are Leg		10 0000
Timothy Joseph C	_	el State of Maryland / Department of Health and For State Certificate of Death	i wentai riy			12 3380
	- 1	Registrar  1. Decedent's Name (First, Middle,Last)	<del></del>	Reg 2. Date of Death	. No.	3. Time of Death
Physiciai Medical Examin	er	Timothy Joseph Gogel	antion of Dogth	Month October 17	Day Year , 2012 4c. County of D	0111 hrs
	H	4a. Facility Name (if not institution, give street and number)  Carroll Hospital Center  4b. City, Town, or L  Westminster			Carroll	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth	lF.	o, Birthplace (State or oreign Country) USA
	-	Usual Residence of Decedent				
any	Ì	10a. State 10b. County 10c. City, Town or Location				10d, Inside City Limits
	اۃ	MD   Carroll Co.   Westminster				1 Yes 2 X No
laryla	Director	10e, Street and Number 10f, Zip Code		100	g. Citizen of What	Country?
the M	盲	13 E. Middle Grove Ct. 21157			USA	
eath with the Maryland items 23a or 28a-f show ust be notified at once.	era	11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hisp If Yes, specify Cuban,	oanic Origin? ( Sp. Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A White, e	American Indian, Black, tc.
death or ite	Funeral	1 Never Married 2 A Married 1 Yes 2 No			Specify: W	hito
ral",	à	3 Widowed 4 Divorced of Section (Specify only highest grade completed)  1 Yes 2 No  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation		ork done	16b. Kind of Busin	
hours fnatu Exan	ted.	Elementary/Secondary (0-12) College (1-4 or 5+)	DO NOT use retir			•
36 hin 72 than dical	Completed	12 Postal Emplo	oyee		Mail C	arrier
d witi	녌	17. Father's Name (First, Middle, Last)	8.Mother's Name	(First, Middle, M Sczer	aiden Surname)	
215 be file ntal H rked o	Be		Clara L	. Seze	rnicki	
21 nould Me is ma	P	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street				
MC slath ar alth ar may		Cheryl Gogel (Wife) 544 Swoop H:  20a. Method of Disposition 20b. Place of Disposition (Name of cert		Glen	Burnie, 20c. Location - C	MD 21061 ity or Town, State
ore, sslar of Heg of Heg		1 Rurial 2 X Cremation 3 Removal from State crematory or other place)				ore, MD
Page ment tant:		4 Donation 5 Other Specify: On-Site Cremato				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee Joseph 22. Name and Address Joseph 2140 N.	H. Brow Fulton	n Jr.	Funeral Balto.	Home PA MD 21217
Physician	$\dashv$	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, a failure. List only one cause on each line.	such as cardiac o	r respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/ IMedical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Heroin Intoxication  Due to (or as a consequence of):				Death
		Sequentially list conditions, b				
	ner	if any, leading to immediate Due to (or as a consequence of):				
	Examine	cause. Enter Underlying Cause (C) (Disease or injury that initiated events resulting in death) Last Underlying Cause (C) (Due to (or as a consequence of):				
cecuted 1 and - transit	Ä	d.				
be exec	dical	UNPENDED 18 per fh g932 11-7-12 #23a, 27, 28a-f, per me, g933 1	2 <b>vt</b> 1-8-12 s	m.		
ox 68760, suth certificate be exe attending physician for use as the burial	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy	Ectopic pregna		23d. Date of de Month	elivery Day Year
tox 68 eath certiles attending for use as	ciar	past 12 months?  4 Pregnant at time of death 5 Other (Specify)				
BO) te death the att	ıysi	1 Yes 2 No 9 Unknown 9 Unknown		1	Alph.	to be the common of death 2
Vital Records, P.O. srician: The law requires that the his certificate has been signed by I director, page 2 should be detach	by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause g	given in Part I.			ute to the cause of death?  Probably 4 Unknown
ds, equire een sig	Completed			24a. Was a		ere autopsy findings available or to completion of cause of
COF	nple			autops perfor	med? dea	ath?
Re( The ficate ; page	ပ်	26 Place	of Death (Check	1 Yes 2	2 No 1	Yes 2 No
ital ician: s certi	Be	examiner?   Hospital: 4   Innationt 2   FR/Outnationt 3   COA	Other	ng Home 5	Residence 6	Other:
of Vision Physical directed di	6	Tes 2 100	ry at Work?	28d. Describe h	now injury occurred	<u> </u>
nd ing	ion	Pending   Fd 10-17-12   fd 12:43 am 1-1	Yes 2 X No	unknow	n	
iSiC r Atte er dea irecto	fica	28e. Place of Injury - At home, farm, street, factory, office b	ouilding, etc.	28f. Location (S	Street and Number	or Rural Route Number, City Iddle Grove Ct
Div	Certification:	Suicide Could not be determined (Specify) found at home		Westmin	ster,Md.	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and complietely filled in by the funeral director, page 2 should be detached for use as the burial - transit		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, do one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion	ate and place, and n, death occurred a	due to the caus at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
To t with To t	Medical	and manner stated.  29b. Signature and title of certifier  29c. Licens				(Month, Day, Year)
61	250	0.0.	M.E.		October 17,	2012
		30. Name and address of person who completed cause of death (Item 23a)				
		Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore	Street, Baltir	more, MD 21	223	
St Regis	tate trar					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2013 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 17872 0> Birthplace (State or Foreign Country) If Under 24 Hrs **Funeral** 8. Date of Birth 219-98-0171 Months Min. (Month, Day, Year) Hours **Director** 1 MM 2 🗆 F ms 23a or 28a-f show must be notified at 10h Count 10c. City, Town or Location Director tomore 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 338 2121 Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status "natural", or iter edical Examiner 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Completed 3 Divorced 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First. Middle, Maiden Surnar ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number aron 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 21. Signature of Funeral Service License Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 2012610 N disease or condition resulting in death) WEEKI Medical Due to (or as a consequence of) **Examiner** masth Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be ex Physician/Medical Division of Vital Records, P.O. Box 68760 as igned by the attending be detached for use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month 1 Yes 2 L 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsv perform 1 ☐ Yes 2 ☐ No Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation within 24 hours after death To the Funeral Director; 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one) Signature and title of certifier 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 0 32. Registra

DHMH 17 Rev 06-2011

Registrar

12-07530 John Hutchins

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 33806 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month **JOHN** HUTCHINS Medical Examiner 2019 hrs October 4, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 3616 Bel Pre Rd Silver Spring Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 068-56-7866 62 oreian Months Days Hours Director 06/06/1950 1 XM 2 F CountryLiberia Usual Residence of Decedent 10a, State IOc. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show a notified at once. MD Montgomery Silver Spring 1 X Yes 2 No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mornell Hygien. Department of Health and Mornell Hygien. If mornell Higher Department is filed and 71 is marked other than "matural", or items 23a or 28a-f also injury or other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 3616 Bel Pre Road #26 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2XX Married 2 X No Yes Black 1 Yes 2 No specify: If Yes, Give Year 4 Divorced Specify: ≥ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Enforcement Officer Government 2+ 18.Mother's Name (First, Middle, Maiden Surname)

Mary Wreh

Caroline Kollie 17. Father's Name (First, Middle, Last) Be Abraham Lincoln Hutchins <sup>19a</sup> Informant's Name/Relationship (Type, Print) Barbara H. Washington Sister <u>Caroline Kollie Hutchins—wife</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10003 Lindly Court, Lanham, MD 20706
3616 Bel Pre Road #26 Silver Spring, MD 209 timore, MD Spring, MD 20906 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State of Heaven Centerry 11/3/2012 Silver Spring, MD Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bianchi 814 Upshur St NW Wash, DC 20011 MOIZS 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical a Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and ician/Medical ★ AMENDED 23a,27,per me,g932 10-24-12 sm #18,19a,b,perFH,G933,11/13/2012,WS X UNPENDED ysician burial -Box 68760, ing phys IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed certificate has been ector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed ✓ Yes 2 No 2 No 1 Yes After this certific funeral director, I 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 🗸 Other: Scene 2 ER/Outpatient 3 DOA 1 V Yes 2 No 28a. Date of Injury (Month, Day,Year) 27, Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Director: 1 Yes 2 No Pending 2 Accident Investigation filled in by n 24 hours after o 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined 4 Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 5, 2012 Tumelle 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registra is Signature State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 33807 State of Maryland / Department of Health and Mental Hygiene Evangeline Harper-Dill 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Dav Evangeline Harper-Dill Medical Examiner 1215 hrs October 16, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2019 W. Lanvale Street **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 213-62-6945 Months Days Hours Director 2X F 06/22/1953 59 M Country) Usual Residence of Decedent in 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore or items 23a or 28a-f show must be notified at once. N/A 1 Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2019 W. Lanvale Street 21217 USA Funera 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes Specify: Black narked other than "natural", event, the Medical Examiner 3 X Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify: <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Airmark 21215-0036 Caterer 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Jerome Lee Bernice Harper 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is Baltimore, MD Kedrick Waters Sr. 9 Wheeler Ave. Baltimore, MD 21223 (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD On-Site Crematory 4 Denation 5 Other Specify ignature of Funeral Same Licens <sup>22.</sup> Joseph H Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 Approximate Interval **Physician** Part I. Ente the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Between Onset and Mairites Death a. Hanging Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed andtran Physician/Medical e attending physician for use as the burial -UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. ģ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed has been s 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page certificate Yes 2 ✔ No Yes 1 of Vital 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene this ER/Outpatient 3 DOA ٩ 1 🗸 Yes No 27. Manner of Death 28a. Date of Injury FOUND: Day, Year) After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Subject hanged self FOUND: Division 5 Pending 1 Yes 2 ✔ No 24 hours after death. Oct 16, 2012 1200 hrs 2 🔝 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide 6 Could not be or Town, State) 2019 W. Lanvale Street, Baltimore, MD determined (Specify) Townhouse / Rowhouse the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 17, 2012 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month)

DHMH 17 Rev 1/2001 OCME 2006

State Registra

32. Registrar's Signature

OGME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 2012 Month Jacqueline Harris Medical October 0 4:00 A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 600 Light Street Apt. 527 Baltimore City Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign (Month, Day, Year) Months 579-40-5102 Hours Director 1 M 2 N F 79 Jan. 24,1933 Virginia rai", or items 23a or 28a-f show Examiner must be notified at Paga 1 and 2 should be fliad within 72 hours aftar death with the Merylend ment of Health and Mantel Hygiana.
ant: If itsm 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Modical Examinan must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director **Paltimore** 1 X Yes 2 No N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 600 Light Street 21230 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces Black. White, etc. 1 X Yes 2 No If Yes, Give Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: White 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Trucking Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Deihl Bernard R. Harris Virginia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene J. Daly, Jr./ Friend 8607 Jessica Lane Perry Hall, MD. 21128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State parmit. Paga 1 s
Department of H
Important: If its
any injury or ot Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-18-12 Hilltop Service Co. Towson, MD. 21. Signature of Funeral Sovice Licenses <sup>22. Name</sup> Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician, disease or condition resulting in death) Herent j Medical Due to for as a consequence of) Examiner perfensive threvo schools cardious rules Disease Sequentially list conditions, Examine ii arry, leading to immediate cause. Enter Underlying Due to (or as a consequence or) Cause (Disease or injury To the Hospital or Attending Physician: The iaw requires that the death cartificate be axacuted within 24 hours after death.

To the Funerel Director: After this cartificate has been signed by the attending physician end compistaly filled in by the funeral director, page 2 should be detached for use as the burial-transi Aftar this cartificata has baan signad by the attanding physician end funaral diractor, paga 2 should ba datachad for usa as tha buriai-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à wellitos Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20a Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 039666 October 17, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fort E

Registrar

31. Date filed (Month, Day, Year)

82. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 4:55 A M VRNIA 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Center Baltmore Keswick Multi-Care it Hm ore 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min **Director** 1 M 2 X 95 215-14-8905 b2 15 17 AL Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location with the Maryland Director 1 X Yes 2 No Baltimore MD NA 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? ms 23a or must be n ö Funeral U.S.A. 21215 3505 Dennlyn Road 2 should be filed within 72 mount.
th and Mental Hygiene.
27 Is marked other than "natural", or items items death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Specify: Black Completed 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools 5Yrs+ Educator 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Ments. Important: If item 27 is marked any injury or one. ည Elvenia Ross Archie Casher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3505 Dennlyn Road, Baltimore, Md 21215 Gwendolyn Browne-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Denation 5 Other (Specify) cemetery, crematory or other place) On-Site 10/18/2012 Baltimore, Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Av March F/H West 4300 Wabash Ave, Baltimenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. 21215 Baltimore, 23a. Part 1. shock, Approximate Interval Between Immediate Cause (Final disease of condition resulting in death) Onset and Death Physician/ MONTHA Metastatic Varina Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year signed by the at Id be detached fo P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deat Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending death. 2 No 2 Accident
3 Suicide
4 Homicide M Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M. D D71079

Registrar DHMH 17 Rev 06-2011

State

navles Street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

101

North

32. Registrar's Signature

M. Hicks

tober

maryland

Towson

2012

21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last 2. Date of Death Physician/ ·e Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Angels Among Us Assisted Living Middle River Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours (Month, Day, Year) Country) Director 218-66-1981 1 □ M 2 💢 F April 11,1935 France 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits traumatic event, the Medical Examiner must be notified 28a-f MD 1 ☐ Yes 2X No Baltimore Randallstown 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 9215 Allenswood Road 21133 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 6 2 1 Never Married 2 Married Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced "natural" Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) Crossing Guard School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, should be file and Mental H is marked o ၉ Charles Lagappe Berthe Bonnin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Importent: If item 27 is eny Injury or other trau Robert Jenkins Friend 1100 Tace Drive, Essex, MD 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Evergreen Mem. Gard 10/18/12 Finksburg, MD 21. Signature of Funda 11824 Reisterstown Road 22. Name and Address of Facility J. Wayne Osterling Eline Funeral Home Reisterstown, MD 21136 s, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between hilure. List only one cause Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Dire to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use compoute to the cause of death? Completed by Division of Vital Records, To the Hospital or Attending Physician: The lew requires within 24 hours after death. To the Funeral Director After this certificate hes been sign completely filled in by the funeral director, page 2 should it. 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 12 No Other: 4 Nursing Home 5 Residence ٩ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 V Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Le rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practition. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 29b. Signature and fittle of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

2 2 2012

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5 Per FH G93311/02/2012 JH
State of Maryland/Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 530 PM Janet M. Haugh Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie Anne Arundel Baltimore Washington Medical Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Days Hours Min. Director 1 □ M 2 🛭 F 81 1931 Massachusetts April 6, Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Glen Burnie 1 Yes 2 X No Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 203 Lisa Lane United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Accountants's Assistant State of MD, Comptroller Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Blanche B. Vaillancourt Camille H. Loiselle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is a any injury or other treesones. 203 Lisa Lane, Glen Burnie, Maryland 21061 Robert T. Haugh/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/22/2012 Glen Burnie, Maryland Glen Haven Mem. Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 20136 421 Crain Highway SE, Glen Burnie, Maryland 2106 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events Due to (or as a consequence of): Exami burial-transit and Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 曹 as the attending properties of the control of the cont IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day 5 Other (specify) cale has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 🗋 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificale to completely filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred X Natural 5 Pending ☐ Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) hair Campbell Chif R 118455 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARON CAMPBELL CRUP 301 HOSPITAZDr Glen Burnie. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33812 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year 20/2 1652 PM Marie Cragg Ickrath Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 155-34-4263 1 M 2X F 71 July 30, 1941 NY 28a-f show PIC: ...
. Page 1 end 2 should be filed within / z. i.v....
trent of Health and Mental Hyglene.
....trent of Health and Mental Hyglene.
...trent of Health and Mental Hyglene.
...trent in the Modical Examiner must be nothing at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Lutherville-Timonium 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 78 Abby Ridge Court 21093 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married ≥ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Baltimore Mental Elementary/Secondary (0-12) College (1-4 or 5+) Social Worker Health System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugene Ε. Cragg Ingalls 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heidi Gage (daughter) 12500 Dover Rd. Reisterstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State Carroll Cremation, Ind 10-25-2012 4 ☐ Donation 5 ☐ Other (Specify) Hampstead, MD 21. Signature of Fundral Service Lice 22. Name and Address of Facility ELINE FUNERAL HOME 11824 Reistertown Rd. Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Pulmonary Pnysician/ t-Mholim Medical Due to (or as a consequence of): Examiner Lancer Sequentially list conditions, if any calls for innectations. Enter Underlying Cause (Disease or injury Due to (or as a normequence of): signed by the attending physician end d be detached for use as the burial-transit that initiated events or Attending Physician: The law requires that the death certificate be execu resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 ≪ Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signe; page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗹 No ဂ္ဂ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospitel Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Deficiency Projections to the best of the momentage, death occurred at the time, date and place, and one to the cause(s) and manner stated.

2 Gentifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of contifier 29d. Date signed (Month, Day, Year) AT-2438946 October, 19,2012 MD

DHMH 17 Rev 06-2011

Registrar

State

Parlowan.

Baltimore MD 21218

East University

3. Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hui

22

Jamue 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 19, 2012 Michael 1 11:46 AM Albert Kavanagh Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours (Month, Day, Year) **Director** 215-10-8233 Usual Residence of Deced 1 X M 2 □ F 94 1918 Maryland July 11. and 2 should be filed within 72 hours after death with the Maryland F Health and Mental Hygiene. It has 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 🗆 Yes 2 🕅 No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8820 Walther Blvd. 21234 #2310 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 N Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Steamfitter U.S. Government 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Albert Kavanagh Swain Marv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Jarrettsville, Maryland 21089 A. Michael Kavanagh, Jr. 3723 Rush Road 20b. Place of Disposition (Name of Duffalley crewal retyer place)
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Special TOMOMENT 10-23-2012 Timonium Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Road Towson, Maryland 21204 21. Signature of fune of Sovice Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) y-cors Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 signed by the attending p IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed the funeral director, page 2 should within 24 hours after death.

To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 DAOther (Specify) WOS DLC ဂ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Sigpature ar dittle of certifier 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

32. Registrar's Signature

Charles ST TOUSEN

M

CHAMES

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend item 5 per th g933 11-27-12 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ X TOPE 3.40 AM Raymond Koch Medical Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death BAL WS . Social Security Number 189–25–1723 If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours XXM 2 D F Country) Director 77 Yrs. Aug. 14, 1935 PA Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 U Yes 2 No Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 5 Bradbury Rd. 21117 12. Was Decedent Ever in U.S.
Armed Forces?
12 Yes 2 No
15 Yes, Give
195 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1952-Black, White, etc. 1 Never Married 2 Married ð Maryland 21215-0036 1 ☐ Yes 2 No Specify 1956 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) 9th College (1-4 or 5+) Mechanic Petro Heating Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen M. Ritzel Thomas Richard Koch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other trau 734 S. Beechfield Ave., Baltimore, MD 21229 Deborah Monk (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State Lakeview Mem'l Park 10/23/2012 Sykesville, MD 4 Donation 5 Other (Specify) 21. So nature of Funcion Service Live 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd., Owings Mills, MD 21117 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Lue to (or as a cons uence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) g 🗌 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, cate has been siç r, page 2 should b 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No Division of Vital æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) |요 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of Srtifier 29c. License number 29d. Date signed (Month, Day, Year) ted cause of death (Item 23a) (Type, Print) 30. Name and address of person 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 2 2 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 02.05 PM Anita M. Kuser 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death imore thes Number HOSPI If Under 24 Hrs. If Under 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months (Month, Day, Year) Hours Country) 213-28-4999 Director 1 M 2 F Yrs. 03/01/1932 MD 80 Usual Residence of Decedent and Mentel Hygiene.
and Mentel Hygiene.
is marked other then "neturel", or items 23e or 28a-f shov
reumetic event, the Medical Examiner must be notified at end 2 should be filed within 72 hours after death with the Maryland Health and Mentel Hygiene. tem 27 is marked other then "neture!", or items 23e or 28a-1 shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Catonsville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 USA 22 Delrey Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Ownhome Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dorothy Tracy Edmund Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Delrey Ave., Catonsville, MD 21228 Collean A. Geldmacher / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 10/22/2012 Glen Burnie, MD 22. Name and Address of Facility 21. Signature of Frequi Service Licensee Hubbard Funeral Home, -Daniel Simons <u>4107 Wilkens Ave., Baltimore, MD 21229</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to for as a consequence of monary Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine tor: After this certificate has been signed by the attending physician and the funeral director; page 2 should be detached for use as the burial-transit resulting in death) Last Physician/Medical lew requires that the death certificete be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Ш Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Division Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sarah Evelyn Lewis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Summit Park Health & Rehab.Ctr Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 8. Date of Birth Birthplace (State or Foreign Country) Days Hours (Month, Day, Year) 124-32-7344 Director 1 🗆 M 2 🔀 F 77 05/10/1935 S.Carolina Usual Residence of Decedent Pege 1 end 2 should be filed within 72 hours efter death with the Maryland ment of Health and Mental Hygiene.
ent: If Item 27 is merked other then "neture!", or Iteme 23e or 28e-f ehov ury or other treumetic event, the Modical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 Franklin Street USA 3302 W. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc <u>چ</u> 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: Black 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) John Hopkins Unknown Housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tom Collins Easline E. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Legrand (Daughter 3306 W.Franklin St. Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of importent: If any Injury or 10/26/12 Owings Mills, 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 21. Signature of Funeral Source Lice JOSEPH AdHessEffeiwn Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death METASTATIC

Due to (or as a consequence of): Physician/ UARITH disease or con ition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Exami To the Hospital or Attending Physicien: The lew requires that the deeth certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burlal-trensit After this certificate has been signed by the ettending physicien end inference, page 2 should be detached for use as the burlal-trensit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 2 No 2 N 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

State Registrar

only one 29b. Signature and title of cert

30. Name and address of person who

Mn

completed cause of death (Item 23a) (Type, Print)

DOMAN

0061765

350 WILLCERS AVE #

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 20, 2012 Shirley Jeanne Party 7:30 a<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 19614 Spooks Hill Road Freeland Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Ye Sept 21, 9. Birthplace (State or Foreign Year) 1934 213-30-9428 Days Hours Min Mary land Director 1 🗆 M 2 🗶 F 78 Usual Residence of Decedent filed within 72 hours are, tal Hygiene.
ed other than "natural", or items 23a or 28a-f show
e other, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Freeland 1 🗆 Yes 2 🖹 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21053 U.S.A. 19614 Spooks Hill Road 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 XMarried 1 ☐ Yes 2 🛣 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
Baltimore County (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Typesetter Exectutive Office Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fondila Friedof Frances Novak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl F. Party-husband 19614 Spooks Hill Rd., Freeland, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Serv Corp 10/24/12 Towson, MD 21204 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd.. Towson, MD 21204 Rd., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Proposale acute empocardial a disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner coronery arting discon Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consecuence of attending physician and I for use as the burial-transi or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) Year been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Type I Diabeter Millitus 1 Yes 2 No 3 Probably 4 Unknown Completed Morbil Obusit 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Hisportensin perform 1 Yes 2 No 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: After this certific ately filled in by the funeral director, **Division of Vital** 25. Was case r rred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 M No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Funer completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number

State Registrar DAVID 1

31. Date filed (Month, Day, Year)

MD

HARTIG MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10155 YORK RD

D0026579

STE 200 COCKEYSVILLE, IND

2012

21030

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Randallstown Baltimore If Under 1 Year | If Under 24 Hrs | Months | Days | Hours | Min. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) **Director** 182-14-1578 90 1 X M 2 D F Yrs. Sept 7, 1922 PA 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Baltimore Pikesville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 608 Ralston Avenue U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Forces Black, White, etc. δ 1 K Never Mamied 2 Married 1 X Yes If Yes, Give 2 No Maryland 21215-0036 1 Yes 2 K No Specify: 3 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Controller Baltimore Contractors Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H 2 Albert Pfeffer Hufford Emma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .90 permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Janet Pfeffer 4216 Kenshaw Niece Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lorraine Park Cem 10/20/2012 Woodlawn Maryland 22. Name and Address of Facility 11824 Reisterstown Road Signatore of Funeral Service Licensee ELINE FUNERAL HOME Reisterstown, MD 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) a. Acute Renol Medical Due to (or as a consequence of) Examiner estur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant Pregnant at time of death 5 Other (specify) Month Day ed by the a Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗹 No Other: 4 Nursing Home 5 Residence 6 V Hospital: ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 ✓ Natural 2 ☐ Accident 3 ☐ Suicide injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 029085

State Registrar

Baltimore.

Box 68760

P.0.

Records,

**Division of Vital** 

133

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's gnature

J-

31. Date filed (Month, Day, Year)

OCT 2 2 2012

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4 101	tate of Marylan	d / Depa	artment of H	lealth	and M	ental Hy	giene	0.0		20010
		State Registrar		Cer	tificate of L	Death			Reg. No.	201	2	_33819
Physic	ian/	1. Decedent's Name (First, Middle, Last)  Keith, Linval	Phillips					2. Date of De Month	Day		ear	3. Time of Death O9:36 PM
Med Exam	lical iner	4a. Facility Name (if not institution, give stree	t and number)		4b. City, Town, or	Location	n of Death	OCT	17 4c.	County of I	)(2 Death	01.301 14
		HARBOR HOSPITA	L		BAL	TIM	10RE					
Funera Directo		5. Social Security Number 077-48-1698  Usual Residence of Decedent	7. Age (In yrs. Ia 81	st birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	Min.	8. Date of Bir (Month, Date 9-10-1	y, Year)		Birthpl Count ama	
and show	ē		10c. City	, Town or Loc	ation	<u> </u>					10	Od. Inside City Limits
Maryl 28a-f otifie	Director	MD Anne Arunde	21 G	len Bu	rnie							1 🗆 Yes 2 🔀 No
th the 3a or t be n	a	10e. Street and Number 122 Warwickshire La			10f. Zip Code					zen of Wha	t Count	try?
eath w	Funeral	11. Marital Status 12. V	Was Decedent Ever in U.S		21061 Vas Decedent of Hi	ispanic O	rigin? (Spec	ify Yes or No-		aica 14. Race - <i>i</i>	America	ın Indian.
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	\$	1 Never Married 2 X Married	Armed Forces? I □ Yes 2 IXNo f Yes, Give ∕ear or Dates.		Yes, specify Cuba  ☐ Yes 2 🔀 No			ican, etc.)		Black, V	White, e	tc.
5-0 2 hour "natu	plete	15. Decedent's Educati (Specify only highest grade co			ent's Usual Occupa		st of workin	7	16b. Kir	nd of Busin	ess/Ind	ustry
thin 7 than the Me	Completed		College (1-4 or 5+)	life. DC	NOT use retired)				Tra	anspo	rta	tion
iled will Hygist other went, t	Be	17. Father's Name (First, Middle, Last)		1ru	ck Drive		her's Name	(First, Middle,				
ylar Id be f Menta arked	은	James Phillip	S			Sy	ylvia	J	орр			
Mar. should and I so is mark		19a. Informant's Name/Relationship (Type, P		14.1	g Address (Street a							
and 2 s Health s tem 27		Rosemary Phillips/w			arwickshi	lre I		Glen B		i MD cation - Cit		
Baltimore, Maryland opernit. Page 1 and 2 should be filled Department of Health and Mental Hy Important: If item 27 is marked oth many injury or other traumatic event		1 Burial 2 X Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	metery, crem cro Cre	ematory or other place		10/20			nsvi.	-	
Dal permit Depart Important in any in		21. Sign sture of Juner   Service Licensee	M0136	- 1	Name and Addres		VII	kley Ru en Burn	uddio nie M	k Fur D 210	nera 061	1 Home
		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one can	ons that caused the death use on each line.	. Do not ente	r the mode of dying	g, such as	s cardiac or	respiratory arr	est,			Approximate Interval Between
Ph sician Medica	_	Immediate Cause (Final disease or condition resulting in death)	Toxic r	nega	colon							Onset and Death
Examine	_	Tooling in doding	Due to (or as a conseque	ence								
1 ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) (	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):								
cuted cuted transi	Examiner	Cause (Disease or injury that initiated events c									E1	
760 cate be executed physician and sthe burial-transit		resulting in death) Last	Due to (or as a conseque	ence ot):								
760 icate be physicate be	ledical	d									_	
x 68	an/N	ZOD. Was decedent pregnant	fyes, outcome of pregnan		Ectonic pregnance	V			2	3d. Date of	f deliver	у
icords, P.O. Box 68760 (an requires that the death certificate be executed has been signed by the attending physician and a 2 should be detached for use as the burial-transi	Physician/M	1 Yes 2 No	Pregnant at time of de Unknown		Other (specify)	,				Month		Day Year
P.O. that the	by Ph	Part II. Other significant conditions contribu	iting to death but not resu	Iting in the ur	derlying cause giv	en in Parl	t I.	23e. Did to	bacco us	e contribut	e to the	cause of death?
dS, I								1 🗆 🕆	Yes 2	] No 3 [	Proba	ably 4 Unknown
COT aw rec as be	Completed							24a. Was a				sy findings available upletion of cause of
The ate									rmed?	deat	h? Yes 2	2 🗆 No
'Ital sician certifi irecto	Be	25. Was case referred to medical examiner?  1  Yes 2 No	tal:		Othe	r.	ath (Check o					
OT V	e: To			R/Outpatient 28b. Time of	3 L DOA 28c. Injury	4 ∟ N		e 5 🗌 Resid d. Describe h			pecify)	
on C arth. r: Afte	icate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work?	? Yes 2 □	_ 1	d. Describe II	ow inquity v	occurred		
<b>Division of Vital Records,</b> tal or Attending Physician: The law requires rs after death. al Director: After this certificate has been signed in by the funeral director, page 2 should b	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	Be. Place of Injury - At hon building, etc. (Specify)	ne, farm, stree	et, factory, office		28	3f. Location (S City or Tow		Number or	Rural F	Route Number,
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medica	29a. Certifier 1 Certifying Physician: (Check 2 Medical Examiner: O only one) 3 Certifying Nurse Pra	n the basis of examination	and/or investi	gation, in my opinior	n, death o	occurred at the	ne time, date a	nd place, a	and due to t	he caus	e(s) and manner stated.
To th within To th comp		29b. Signature and title of certifier	1	,	29 c. License	number				signed (Mo		
,		+ the			RES	0	01		10/1	7/20	12	
		30. Name and address of person who completed Hussan Mchameter	3001 S.	23a) (Type, Pr	our St,	Bal	Himer	6 MI	2	1225		
Sta Regist	ate rar	31. Date filed (Month, Day, Year)  OCT 2 2 2012	3 CO   5.	par	4							
				_								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ALBERT 17:20 PM 13 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Sinai BALTIMORE Haspita Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8 Date of Birth (Month, Day, Year) Director 1 XM 2 F 212-20-6184 05/08/1925 MD Usual Residence of Decedent on Marked Hyglene.
Is marked other then "neture!", or items 23e or 28e-f show marked other then "neture!", or items 23e or 28e-f show reumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 √ Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 2434 W. BELVEDERE AVENUE 21215 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed 3 √ Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ OWNER AUTOMOBILE SERVICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည should be PERLOW BERTHA LITVAK-GOLDBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Heelth e Item 27 is HOWARD PERLOW/SON 3512 OLD COURT ROAD, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pege 1 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State permit. Pege Depertment of Importent: If eny injury or 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM 10/15/2012 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mass Ce 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death ⊕nysician/ disease or condition resulting in death) neumonia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injuly that initiated events resulting in death) Last Examine Due to (or as a consequence of): ettending physicien end I for use es the burial-transit or Attending Physician: The lew requires that the deeth certificate be executed Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 23d. Date of delivery 1 ☐ Live Birth 2 ☐ retail 3 ☐ 4 ☐ Pregnant at time of death in the past 12 months?
1 Yes 2 No Month Day signed by the ef 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Piabetes 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physicien: The lew within 24 hours efter deeth.

To the Funeral Director: After this certificate has a completely filled in by the funeral director, page 2: autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical å 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 ☐ No Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) "Patel MD NIPSH P6495 locteben 13, 2017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . SINAI HOSPITAL OF BALTIMORE, MARYLAND NILESH PATEL MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar 3382 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1 d Month Brenda Randall 16Day 2ď 12 2:17P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris N/A Baltimore Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 216-72-4846 Days (Month, Day, Year) 06/01/1959 Director 1 M 2 STF 53 Yrs. Maryland Usual Residence of Decedent 10a. State 10b, County 10c. City, Town or Location Injury or other traumatic event, the Madical Examiner must be notified at Director 10d. Inside City Limits N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 3222 Yosemite Ave. 21215 U.S.A. or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Black White etc. ģ 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 X Widowed 4 ☐ Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Werner (Specify only highest grade completed) Flementary/Secondary (0-12) 8th Grade College (1-4 or 5+) Truck Driver Trucking Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Jones Mabel Hancock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charleen Price(daughter) 3222 Yosemite Ave., Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 KD Cremation 3 D Removal from State on-site Crematory 10/24/17 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service License 22JosephdreHofBrown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD21217 24a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ediate Cause (Final Onset and Death Physician/ EXE BROVASCU Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to instruct cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Exar attending physician and for use as the burlal-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical BLenbA RANDALL Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 X No
9 Unknown Pregnant at time of death Other (specify) Month Day signed by the ar 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 X No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 🗌 Yes 2 No filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specific) After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi death. Accident Investigation Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29b. Signature and of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 2 Registrar

DHMH 17 Rev 06-2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene
		Registrar  Certificate of Death  1. Decedent's Name (First, Middle, Last)  2. Detection of Death  3. Detection of Death
Physic Med	lical	Gail Wanda Rowell  Month  Day Year 20/2 10:16 p. M
Exam	ıner	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death Fort Washington Hospital  4c. County of Death Prince George's
Funera Directo	r	5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 6. Sex 1. Age (In yrs. last birthday) 6.
yland -f shov ed at	ctor	
he Mar or 28a	Dire	MD Prince George's Oxon Hill  10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?  10g. Citizen of What Country?
with t is 23a	Funeral Director	308 Ellsworth Place 20745 US
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by Ful	1 Never Married 2 Married 1 Yes 2 No
15-( 72 hou n "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working)  16b. Kind of Business/Industry
212 within vgiene.	Sor	Elementary/Secondary (0-12) College (1-4 or 5+) life. DO NOT use retired)  12 Contract Specialist Federal Government
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	To Be	
Mary nd 2 should saith and h n 27 is me er trauma		19a. Informant's Name/Relationship (Type, Print) Michael Rowell/Husband  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 Ellsworth Place, Oxon Hill, MD 20745
Baltimore, oermit. Page 1 and Department of Hea Important; If item important; If item any injury or other page.		20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20c. Location - City or Town, State   20c. Lo
Balt permit. Departr Imports any injr		21. Synature of Funeral Size of Licensee 22. Name and Address of Facility Codar Hill Funeral Home, Inc. 4111 Pennsylvania Avenue, Suitland, MD 20746
		23a. Part . Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.
Physician Medica		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Pulseless Electrical Activity 2 hvs
Examine	7	Due to (or as a consequence of):  Congestive Card a My o pathy  4 4 7 5
ted I	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)  Clause (Disease or injury)  Due to (or as/a consequence of):  Clause (Disease or injury)
'60 ate be executed physician and the burial-transit	al Exe	that initiated events resulting in death) Last Due to (or as a consequence of):
	ledical	d
ords, P.O. Box 68760 requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi	Physician/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 months?
Division of Vital Records, P.O. In the Hospital or Attending Physician: The law requires that the finn 24 hours after death.  The Funeral Director: After this certificate has been signed by the mpletely filled in by the funeral director, page 2 should be detach		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes   2   1   Yes   3   Probably   4   Unknown
Records, The law requires ate has been sig	Completed by	Ave Was an 24b. Were autopsy findings available prior to completion of cause of
<b>/ital Reco</b> sician: The law is certificate has to director, page 2 s		Dank S Muhh Jyp T   performed?   death?   1   Yes 2   No
Vita vysicia vysicia vis certi	To Be	26. Place of Death (Check only one)    Solve   Check only one   Check only one
n of ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of injury 28c. Injury at work? 28d. Describe how injury occurred work?
Division of Vital tal or Attending Physician; rs after death. al Director: After this certific ed in by the funeral director.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be determined determined    28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)
Dividing of the control of the contr		Sily 6. Young dates
Division of Vital To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
To with		29b. Signature and title of certifier  29c. License number  0/0/34433  29d. Date signed (Month, Day, Year)  10/18/12
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BIDI HINSON FAVE ROLS SK 415  AUSON M. Valantik MD Auxandna VA 22306
Sta Registi		31. Date filed (Month Day Year) 2012 2. Registrar's Signa are
DUMH 17 Pay 06		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ Medical Pacility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Go Dallston If Under 1 Year I f Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Davs Hours Director 218-22-5492 1 □ M 2XXF 85 Aug. 2, 1927 New York or 28e-f ehov 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director MD Baltimore Reisterstown 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 239 218 Chatsworth Ave. 21136 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ò ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12th Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith end Mentel F 27 Is merked of treumetic ever မှ Wilbrod Alfred Veillette Regina Cloutier permit. Pege 1 and 2 st.
Department of Health en.
Importent: If Item 27 Is meny injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Nicodemus Rd., Reisterstown, MD 21136 Michelle Y. Burgesen (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 10/24/2012 Pikesville, MD Signature of Funeral Sentes License 22. Name and Address of Facility Eckhardt Funeral Chapel, 11605 Reisterstown Rd., Owings Mills, MD 21117 Part/1 firster the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shork, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) True to (or as a construence of): Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause Disease or injury Hospitel or Attending Physician: The lew requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760/ Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 menths?

1 Yes 2 No
9 Unknown Month P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending I Director: At od in by the fo 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Vithin 2 only one) 29b. Signature and title of certifi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar

X DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Andrew J. Robertson Ochober 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death AGNES BALTIMORE MOSPITAL ocial Security Number If Under 1 Year If Under **Funeral** 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours (Month, Day, Year) Director 275-20-4331 1 M M 2 | F 86 04/19/1926 Scotland ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b, County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Catonsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 715 Maiden Choice Lane, HV508 21228 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. \$ 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) National Security 4 Security Analyst Agency Be 17. Father's Name (First, Middle, Last) should be file and Mental H is marked of 18. Mother's Name (First, Middle, Maiden Surname) John Robertson Clara Fairley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Carolyn J. Wood / Step-daughter 8008 Phirne Rd., East, Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Vet. Cem.: 10/26/2012 Crownsville, MD 21. Signature of Funeral Service Licensee Hubbard Funeral Home, 4107 Wilkens Ave., Baltimore, MD 212 Daniel Simons 23a. Part 1. Ent. thus lease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ AQUIRED PNEUMONIA disease or condition resulting in death) DINUMMO Days Medical Due to (or as a consequence of Examiner Secreptially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, director, page 2 should 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 ☐ No Inpatient 2 I ER/Outpatient 3 I DOA 24 hours after death.

Funeral Director: After this letely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geatin occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one) 29b. Signature and title of certifier MD. 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE AGRAWAL 900.5 · CATON AVE 31. Date filed (Month, Day, Year) State 2. Registrar's Signature OCT 2 2 2012

DHMH 17 Rev 06-2011

Registrar

B

DD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33825 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 16 2012 OCTOBER Kay Helene Ellerbe Stancil 3:57 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min (Month, Day, Year) Director 091-40-8536 1 □ M 2**X**□ F 07/17/1948 New York Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3702 Dorchester Road 21215 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maarifa Elem. Elementary/Secondary (0-12) College (1-4 or 5+) Years Founder/Dir./Educator Middle School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ۵ Russell Ellerbe Martha Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3702 Dorchester Rd. Baltimore, MD 21215 Kimani A. Stancil (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 10/23/12 4 Donation 5 Other (Specify) On-Site Crematory: Baltimore, MD 21. Si pature di pineral Service Lic 22JosephdreHofFaBrown Jr. Funeral Home PA active MD 21217 2140 N.Fulton Ave., Baltimore, 239 Part 1. Enterville disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death ceremovasular accident Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): anding physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ ō in the past 12 months? Month Day Pregnant at time of death Year 24 hours after death.
• Funeral Director. After this certificate has been signed by the a tetely filled in by the funeral director, page 2 should be detached? 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ hypertusion atual Fibrillation Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 ☐ Yes 2 ☑ No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending work? Investigation 3 Suicide 4 Homicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fi 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 00057347 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 6701 N. Charles St Balkning MS 21204

DHMH 17 Rev 06-2011

State Registrar

Stabe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month 8:04 рм Louise Sembly Medical October 201 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 517 W.Seminary Avenue Lutherville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Director 216-24-0341 93 1 X M 2 | F Yrs 2/15/1919 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If teem 27 is marked of them than "natural", or items 23a or 28a-f show any Injury or other 27 is marked of them than "natural", or items 20a or 28a-f show any Injury or other 27 is marked of the than "natural", or items 20a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Lutherville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 517 W.Seminary Avenue 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Completed 3 ₺ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 10th grade Custodian Baltimore County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John L. Williams Sr. Angeline Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence Fields/Neice 311 Lennox Ave. Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10/25/12 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet.Cemetery Owings Mills, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd.Baltimore MD.21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Mago Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) and Il-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Live Beath 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2. N **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{R}\) Residence 6 \(\sum \) Other (Specify) 1 ☐ Yes 2 💢 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Jerlene Skaggs 10 3:19 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Joseph Richey Hospice Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) North Funeral 8 Date of Birth Days Hours Min (Month, Day, Year) Director 139-30-3350 1 M 2 X F Carolina 10/11/1938 Usual Residence of Decedent i Hygiene. I other then "natural", or items 23e or 28a-f shov vent, tra Medical Examinar must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21206 6615 Fairdel Avenue USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married \$ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify specify:Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Housewife 10th\_grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked or မ Department of Health and Ments Importent: If Item 27 is marked any Injury or any å Early Lynch Flora Cornelius Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Lynch/Sister 2710 E.Madison Street Baltimore, MD. 21205 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10/99/12 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) St.Stanislaus Cemetery 21. Signalum Funeral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Rd.Baltimore, Maryland 21206 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). burial-tran Due to (or as a consequence of) resulting in death) Last ettending physician for use es the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) ed by the et detached for 9 Unknown g Unknown Part II. Other signifi conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been signe page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available autopsy
performed?

1 Yes 2 No prior to completion of cause of death?

1 Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funerel Director: After this certificate I completely filled in by the funeral director, pag 25. Was case ref and to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 No မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred ✓ Natural 5 Pending injury 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, dueth accurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29c. License number 29d. Date signed (Month, Day Year)

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / D	epartment of Health	n and Mental Hygiene
			Certificate of Death	n Reg. No. 2012 33828
Physic	ian/	1. Decedent's Name (First, Middle, Last)		2. Date of Death  Month  Day  Year  3. Time of Death
Med	lical	4a. Facility Name (if not institution, giye street and number)		OCTUBE 217 Year 12 9:25 PM
Exam	iner	MEDSTAR HAIRBOR HOSPITA	4b. City, Town, or Location	on of Death  4c. County of Death
Funera	al	5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	day) If Under 1 Year If Under 1 Months Days Hours	ler 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)
Directo	or	214-52-8967	rs.	Min. 1–18–1949 Country) MD
and Show	٥	10a. State 10b. County 10c. City, Town	or Location	10d. Inside City Limits
Maryla 28a-f	rect	MD Anne Arundel Ba	ltimore	1 ☐ Yes 2 ☐ No
th the	Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
ath wii	nuer	5724 Pope Street  11. Marital Status 12. Was Decedent Ever in U.S.	21225  13. Was Decedent of Hispanic C	USA  Origin? (Specify Yes or No- 14, Race - American Indian,
or ite	by F	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	If Yes, specify Cuban, Mexic	can, Puerto Rican, etc.)  Black, White, etc.
UUS aff urs aff tural",		3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 ☐ XNo Speci	ify: Specify: White
75-1 72 ho n "nat	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation 'Give kind of work done during me ife. DO NOT use retired)	ost of working 16b. Kind of Business/Industry
212 within yiene.		Elementary/Secondary (U-12)   College (1-4 or 5+)	vironmental Con	nsultant Air Analysis
Maryland 21215-50036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Be Be	17. Father's Name (First, Middle, Last)	18. Mc	other's Name (First, Middle, Maiden Surname)
Tarylan should be fil and Mental is marked aumatic ev	2	Edward Schramek		th Phebus
Maryl 2 should Ith and Me 27 is mar		Land to the state of the state		nber or Rural Route Number, City or Town, State, Zip Code) Ltimore MD 21225
or Healt of Healt fitem 2		20a. Method of Disposition 20b. Place of	Disposition (Name of	Date 20c. Location - City or Town, State
altimore, rmit. Page 1 and partment of Hea portant: If item y injury or other		Thousan 2 th Oremation 3 the noval normatate	crematory or other place) Crematory	10-20-2012   Catonsville MD
bant permit. Departi Import any inj	ouce.	21. Simulation Licensee M01364	22. Name and Address of Fact 421 Crain Hwy	Kirkley Ruddick Funeral Home SE Glen Burnie MD 21061
		23a. Part 1 Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.		as cardiac or respiratory arrest, Approximate
~ Ph_siciar		Immediate Cause (Final disease or condition	A LUNG	Interval Between Onset and Death
Medica Examine	_	resulting in death)  Due to (or as a consequence of	):	
	ē e	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	):	
A ansit	Examiner	Cause (Disease or injury that initiated events c.		
te be executed hysician and the burial-transit	Ä	resulting in death) Last  Due to (or as a consequence of	):	
f60 ate be physicia	edical	d		
certifica nding p	Ž/C	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
<b>Box</b> death of the attented for the	Physician/Me	in the past 12 months?  1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	Month Day Year
of the catache etache	Phys	9 Unknown  Part Il/Other significant conditions contributing to death but not resulting in	a the underlying cause given in Dr	art I 200 Pid Asharan una santilhata ta tha causa at death?
ords, P.O. Box 68/r requires that the death certificat been signed by the attending ph should be detached for use as the	Completed by	TOBACCO USE	the underlying cause given in re	art I. 23e. Did tobacco use contribute to the cause of death?  1  Yes 2  No Probably 4 Unknown
Cord	plete			24a. Was an autopsy autopsy prior to completion of cause of
Re The	S E			autopsy prior to completion of cause of death?  Yes 2 \[ \sum \] No 1 \[ \sum \] Yes 2 \[ \sum \] No
ital R6 sician: The certificate irector, pag	Be	25. Was case referred to medical examiner?	26. Place of D	Death (Check only one)
Phys rthis eral dir	<u>۾</u>	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out 27. Manner of Death 28a. Date of injury 28b. Ti	patient 3 L DOA 4 L	Nursing Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred
on C nding ath. r: Afte	ertificate:	1 Natural 5 Pending (Month, Day, Year) in 2 Accident Investigation	jury work? M 1 ☐ Yes 2	
Division of Vital lal or Attending Physician: rs after death. al Director: Affer this certific ed in by the funeral director.	erti	3	n, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificethy filled in by the funeral director,	cal	29a. Certifier 1 Certifying Physician: To the best of my knowledge, d	feath accurred at the time, date of	and along and due to the aguar(a) and manner as stated
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check 2 — Medical Examiner: On the basis of examination and/or	investigation, in my opinion, death	and place, and due to the cause(s) and manner as stated.  h occurred at the time, date and place, and due to the cause(s) and manner stated, date and place, and due to the cause(s) and manner as stated.
To th withir To th		29b. Signature and title of certifier	29c. License numbe	er 29d. Date signed (Month, Day, Year)
		* Kehard Z & MD	100	045/7 OctoBER 18, 2012
入		30. Name and address of person who completed cause of death (Item 23a) (TRICHAR OF TISHE MID 3	1905 E 17	TCHIE HIWAY BROOKLYN MS
S Regis	tate trar	31. Date filed (Month, Day, Year)  QCT 2 2 2012	barker	/
		The state of the s		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33829 Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 201<sup>Yea</sup> MILDRED SNYDER 5:40 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FUTURE CARE CHERRYWOOD REISTERSTOWN BALTIMORE Social Security Number 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Hours Days Director 215-46-6586 1 □ M 2X F 97 06/13/1915 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2📈 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 31 COBBLER COURT 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 V Widowed 4 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ FRIEDMAN REBECCA LEVIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARRIET COHEN/DAUGHTER COBBLER COURT, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BETH EL MEMORIAL PK 10/19/2012 RANDALLSTOWN, MD Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box  $68760^{<}$ IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ➡No
9 ☐ Unknown 4 Pregnant at time of death
9 Unknown Day 5 Other (specify) Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Cho 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No BB 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Aursing Home 5 Residence 6 Other (Specify) ဥ 1 🗆 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 037573 17,2012 30. Name and address of person who complete f death (Item 23a) (Type, Print) Po Nogis MO 21802 2613

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #ईर्वा १ कि अवेग्रिक्त मिल्डिकिने हो में देश बेली and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 800 M Physician/ Day Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Silver H If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. S239=60-1280 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. Hours Country) Director 1 🗆 M 2 🔀 01-29-1938 N a or 28a-f show be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at ones. 10b. Coun 10c. City, Town or Location 10d. Inside City Limits Director Mont. ark 1 Yes 2 ☐ No akoma 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral SA ORROL 20 CHUC 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify G( 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Education Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden မ Burd 19-14-ying Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Herman husband arroll Ave. Takoma Paruc Mo SCOLL Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, Brentwood, MD 10-20-2012 INCOIN Wischan Fulveral Home Signat Ir 22. Name and Address of Facility 752701d Hexanding Ferry Rd Clinton MID 20135 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician DIRator UNKNOWK disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami and the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: filled in by the funeral director, page 2 should be detached for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown a | Ilnknown signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by KIGNEY 1 Yes 2 No 3 Probably 4 Junknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: ျ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: within 24 hours after death. To the Funeral Director: After Natural (Month, Day, Year) injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatyfe 29c. License number 32 332 30. Name and address of pers on who completed cause of death (Item CORGITAVE. SILVERSPRING MD ZOGOZ 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a, perFH, G932, 10/31/2012, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 07.57 Medical Facility Name (if not institution, giyle 48. City, Town, or Location 4c. County of Death Examiner 100 Social Security Number 8. Date of Birth (Month, Day, 03/11/ 7. Age (In yrs. last birthday, If Under If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🔀 F Months Hours Min 90 Yrs MD **Director** 262-28-6878 Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland notified at 10d. Inside City Limits Director Baltimore 1 X Yes 2 ☐ No MD 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Examiner must be items 23a Funeral 21223 128 S. Gilmore St. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married o, þ 1 ☐ Yes 2 🗶 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗷 No Specify: Specify: White "natural", Completed 3 X Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Nursing Home Nursing Assistant and Mental Hygie is marked other injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Annie L. Cambell permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any injury or other traumatic Aba Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 128 S. Gilmore St., Baltimore, MD 21223 Stewart / E. Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 10/19/12 Glen Burnie, MD Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Daniel Simons Baltimore, MD 21229 4107 Wilkens Ave 23a. Part 1. Sater the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and ending physician are as the burial-Physician/Medical P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ atter in the past 12 fonths?

1 Yes 2 No for Month Day Year Pregnant at time of death signed by the a Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Yes Yes 2 No 3 Probably 4 Unknown Completed should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has tirector, page 2 s autopsy perform 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this Manner of Deal 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury work? 1 ☐ Yes 2 ☐ No death. М Accident Investigation 24 hours after deat Funeral Director: completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🕰 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NIE 31. Date filed (Month, Day, Year) ltimore State Registrar's Signature

H DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra 33832 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 1<sup>D</sup>7 201 2 oct. 3:25A M Robert Lee Tyler Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospice Dove House Westminster Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours (Month, Day, Year) Country) 69 212-42-0815 Director 1 🖾 M 2 🗆 F Yrs 10-8-1943 MD Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Westminster Carroll MD 1 X Yes 2 No. 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 Funeral 105 E. Main St., #10 USA death v 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 Xo
If Yes, Give Black, White, etc. 2 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify Specify: white Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Property Management other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George P. Tyler, Ida A. Watts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21157 10 Distillery Dr., Suite G-1, Westminster, MD Jessica Nusbaum-PR 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 10/25/12 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) Central MD Crem 21. Signature of Funeral Service Sicensee 22. Name and Address of Facility Fletcher Funeral & Cremation Main St., Westminster, MD 21157 homes 254 Ε. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Interval Between Immediate Cause (Final Onset and Death Physician Thato Octor disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examin physician and s the burial-transi Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death been signed by the a should be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate has t completely filled in by the funeral director, page 2 s performed 1 ☐ Yes 2 ☐ No Yes 2 L M Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No |요 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) DOV € Wee 28a. Date of injury (Month, Day, Year) 27. Manner of Oeath 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Adatural
2 Accident
3 Suicide
4 Homicide 5 Pendina work? 1 ☐ Yes 2 ☐ No М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner 15 the basis of my knowledge death occurred at the time, date and place and due to the cause(s) and manner stated (Check only one 29b. Signature and fitte me and address of person who completed cause of death (Item 23a) (Type, Print)

here Rice, 680 Poole Rd., Suite

DHMH 17 Rev 06-2011

State Registrar

Kobert 31. Date filed (Month, Day, Year) Poole

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 1915 73 IURNBAUGH 2012 Octobe 18 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Reisterstown Futurecare Cherrywood g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Aug 29, Year 1935 Months Days Hours 1 □ M 2 🕱 F Maryland 77 **Director** 215-32-9359 Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10c. City, Town or Location 10a. State 10b, County event, the Medical Examiner must be notified at Director 1 Yes 2 X No Reisterstown MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral items 23a U.S.A. 21136 304 Cantata Court Apt Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 **X** No "natural", or ģ 1 Never Married 2 Married 1 Yes 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) Sales Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) permit. Page 1 and 2 should be a Department of Health and Menta Important: If item 27 is marked any injury or other traumatic events. ٥ Jane E. Hines Frederick Baugher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 23 Ewing Drive Reisterstown, MD Daughter Valerie F. Morazzani 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Evergreen Mem. Gardens 10/25/12 Finksburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 11824 Reisterstown Road Signature of Funeral Service Licensee 21136 ELINE FUNERAL HOME Reisterstown, MD Se ren usun 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 6 mes Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Petal death
Pregnant at time of death IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 →No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No ☐ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital the funeral director, Certificate: To Be examiner? Hospital Other: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred iniury 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Directo completed filled in by the 4 Homicide determined Medical 1 & Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D37573 Octobe 18, 2012 completed cause of death (Item 23a) (Type, Print)

State Registrar 30. Name and address of person who

31. Date filed (Month, Day, Year)

Jef

ZIRUI MO

3 Registrar's Signature

DHMH 17 Rev 7/2009

2613

21802

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10 Medical Name (if not institution, give street and number) Examiner 4c. County of Death LEN BURNIE thre Hounde **Funeral** 9. Birthplace (State or Foreign 8. Date of Birth 490-52-2622 (Month, Day, Year) Director 1 □ M 2x F St. Iouis, MD Yrs 10-15-1946 items 23a or 28a-f shover must be notified at 10b. County **Prince Georges** 10c City Town or Location death with the Maryland 10d. Inside City Limits Director Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 8411 Autumn Way 20735 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ortant: If item 27 is marked other than "natural", or iter injury or other traumatic event, the Medical Examiner. Armed Forces?

1 Yes No Black, White, et-1 Never Married 2 Married and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify. Black 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene, is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Registered Nurse Covernment Be 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Lois Audley Watkins Horace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health sitem 27 i Marion Vaughn Husband 8411 Autunn Way Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Department of Important: If it any injury or o 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jefferson Memiral Cem 10/25/12 St. Louis, MO 21. Signature of Funeral Service License 22. Name and Address of Facility Blanchi 814 Upshur St NW, Wash, DC 20011 M0125 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) true Renal Disease Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events burial-trai resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ō Month Year Pregnant at time of death 5 Other (specify) q | Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of Hospital or Attending Physician: The law After this certificate has autopsy perform death? 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: ပ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 24 hours after death. Funeral Director: A letely filled in by the fi 1 🗌 Yes 2 No Accident Investigation 6 ☐ Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F 3 only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signature and little of certifie mo to completed cause of death (Item 23a) (Type, Print) DRIVE GLENBURNIE MD

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day

OCT 22

2012

12-07610 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Edith Marie Von Nordeck State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month **Medical Examiner** 1845 hrs EDITH MARIE VONNORDECK October 7, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Ebenezer Road at Earls Beach Road Middle River **Baltimore County** 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Months Davs Hours Director 212-62-6323 County 2 XF М 60 3/9/1952 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No or items 23a or 28a-f show must be notified at once. or 28a-f show MD BALTIMORE MIDDLE RIVER Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3 MANGO TRAIL ö 21220 IISA 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner 3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: WHITE <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 SECRETARY 12 MOVING AND STORAGE 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) UNKNOWN FLORILLA SPARKS 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEP MARK VONNERDECK, MANGO TRAIL, SON MIDDLE RIVER, MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State ATLANTIC CREMATORY 10/16/12 GLEN BURNIE, Donation 5 Other Specify: ignature of Runeral Service Licensee 22. Name and Address of Facility SKARDA FUNERAL HOME MOHAD 2829 HUDSON STREET BALTIMORE 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a Neck Injury Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and for use as the burial - transit d. sician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of death Other (Specify) this certificate has been signed by the atte il director, page 2 should be detached for i 1 Yes 2 ✓ No 9 Unknown g Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 ✓ No 3 Probably 4 Unknown pleted 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Com 1 🗸 Yes Yes 2 No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene ۵ 1 Yes No 28a. Date of Injury (Month Day,Year) Oct 7, 2012 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Driver of auto involved in collision \_\_\_ Natural 1828 hrs Pending Yes 2 V No filled in by the 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Ebenezer Rd @ Earls Beach Rd., Middle River, MD determined (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Fuoeral Director: within 24 hours after completely

DHMH 17 Rev 1/2001

OCME 2006

State Registrar

Jack Titus MD.

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a)

Deputy Chief Medical Examiner

22. Registrar's Signature

arks

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

October 8, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ WILLIAM RUSSELL WILSON M aTOBER 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BACTIMORE N/A AGHES If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Months Days Hours Min. Director 231-20-9412 1 🖾 M 2 🗆 F 87 Yrs. 9-10-1925 VIRGINIA Usual Residence of Decedent 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐XYes 2 ☐ No N/A BALTIMORE MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 317 ALLENDALE ST. 21229 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: Specify: BLACK Completed 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) -12--Ò-LABORER BETHLEHEM STEEL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ LANDON WILSON MILLIE ANN THOMPSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY RANDOLPH(NIECE) 1340 N. ROLLING RD. CATONSVILLE, MARYLAND 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 Durial 2 Ch mation 3 
Removal from State GARRISÓN FOREST VETERANS 10-23-2012 OWINGS MILLS, MD. 4 Donation 5 🔲 Other (Specify) THAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. JONA 1721-27 N. MONROE ST. BALTIMORE MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) LUNG CHHCEL Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami ause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>&</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an

Pnysician Medical Examiner

28a-f shov

or than "neture!", or items 23e or 28a-f sho

flled within 72 hours efter death with the Maryland

altimore, Maryland 21215-0036

t. Pege 1 end 2 should he tment of Health and Men rtant: If item 27 is mark

partment of hoortant: If its

Depart Impor any in

**Director:** After this certificate has been signed by the attending physicien and d in by the funeral director, page 2 should be detached for use as the buriel-transli or Attending Physician: The law To the Hospitei or Attendir within 24 hours after death, To the Funerel Director: Af completely filled in by the fu death,

Be

٩

Certificate:

Medical

P.O. Box 68760

Records,

ivision of Vital

WISON

24b. Were autopsy findings available prior to completion of cause of autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

	2 Accident			М	1 ☐ Yes 2 ☐ No	1	
	4 Homicide	6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, facto	ory, office	28f. Location City or To	(Street and Number or Rural Route Number, own, State)
ı	-11-						
ı	29a. Certifier	1 Certifying Physici	an: To the best of my know	ledge, death occurred	at the time, date and place,	and due to the	cause(s) and manner as stated.
	(Check	2 Medical Examiner	r: On the basis of examination	n and/or investigation, i	n my opinion, death occurred	at the time, date	and place, and due to the cause(s) and manner stat
ì	only one)	3 ☐ Certifying Nurse F	Practitioner: To the best of	my knowledge, death or	courred at the time, date and p	lace, and due to	the cause(s) and manner as stated.
ĺ	29b. Signature an	d title of certifier		25	c. License number		29d. Date signed (Month, Day, Year)

25. Was case referred to medical

2 🗹 No

5 Pending

examiner?

1 🗌 Yes

27. Manney of Death

1 Natural

31. Date filed (Month,

D60 72302

BACTIMORE, MD

Other:

1 ☐ Yes 2 ☐ No

28c. Injury at

2012 OCTOBERS 11

21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAUCEN BEST 955 S CPTON AUE

State Registrar egistrar's Signature

28a. Date of injury (Month, Day, Year)

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 1745 CM **Physician** Antonio October 16 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Johns Hopkins Bayview Medical Center Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 - F 215-96-0329 Maryland 38 04/22/1974 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with rent of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or items 23a or 2300 Mt. Royal Terrace #6 Funeral 21217 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 XNo Black. White, etc 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 0 altimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 XNo ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Medical Elementary/Secondary (0-12) College (1-4 or 5+) Nursing Home the 12 Health Care Worker 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, 17. Father's Name (First, Middle, Last) Be Unknown Shellda White ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Shellda White (Sister) 2300 Mt. Royal Terrace #6 Balto., MD 21217 Department of Healt Important: If Item 2 any Injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State On-Site Crematory 10/20/12 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses <sup>22</sup> Joseph H. Brown Jr. Funeral Home PA illiamo 2140 N. Fulton Ave. Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final y poxic **Physician** disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Astiretion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Examine Due to (or as a consequence of) that the death certificate be executed Nousea vomiting the attending physician and ched for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, 2 ESLO Physician/Medical UTI IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 2 No should be detached P.O. 9 Unknown een signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has ! pege 2 autopsy performed? 1 Yes 1 Yes certificate **Division of Vital** director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 🕅 Natural 5 Pending 1 | Yes 2 | No death. investigation 2 Accident Director: 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined 4 - Homicide or A City or Town, State) within 24 hours a Hospital 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Registrar

11595

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

Gerardo

Day, Year)

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

32. Registrar's Signature

29c. License number

Onoco

29d. Date signed (Month, Day, Year)

16

2012

October

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33838 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Day Chappell Wagner 12 Oct. Medical 6:00 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A 42 W. West Street Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Dav. Year) Min. Hours Director 1 □ M 2 😾 F 216-62-3850 57 6/13/1955 Maryland item 27 is marked other than "natural", or items 23e or 28a-f show other traumatic event, the <u>Medical Examiner must be notified at</u> Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23e or 28a-1 sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A 1 Ves 2 No Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 42 W. West Street 21230 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black White etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Specify: Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Years Teacher Day Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Miles Wagner Ruth Mae Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pastor Constance Brown(sis) 42 W. West St., Baltimore, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it eny injury or o 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 10/16/12 Baltimore, MD 4 Donation 5 Other (Specify) King Mem. Park 22. Name and Address of Facility Joseph H. Brown, Jr 2140 N. Fulton Ave, Jr. Funeral Home, P.A. ve. Baltimore, MD 21217 Part 1. Enter the disease, or complicatione that shock, or heart failure. List only one cause on that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwe nmediate Cause (Final Onset and Death Physician ) Medical resulting in death) Examiner Sequentially list conditions, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and I for use as the burial-transi or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 morths?

1 Yes 2 No
9 Unknown Year ate has been signed by the a page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 6 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury reral Director: A 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 2012 Mame and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hanover Date filed (Month, Day

DHMH 17 Rev 06-2011

			Please	e Type or F							•		•	ble.		
		•	For State Registrar	State of	Marylan	-	artmen <i>tificate</i>			and M	lental Hy	/giene Reg. N	20	12	33839	
	Physicia		1. Decedent's Name (First, Middle, La Kathleen Willi	,							2. Date of Death Month Day Year 3. Time of Death					
A.	Medic Examin		4a. Facility Name (if not institution, give		er)		4b. City,	Town, or	Location of	of Death	10		c. County o	012 of Death	10:36A <sup>™</sup>	
The state of the s			Joseph Richey  5. Social Security Number 6.		Age (In yrs. la	act hirthday	Bal If Under			24 Hrs	0 Date of B		N/A	O Diah	Jane (CA-A	
, I	Funeral Director			1	3 9	Yrs.	Months	Days	Hours	Min.	. (Month, Day, Year)			Count	place (State or Foreign try)North olina	
7.36 AM	f show	tor	10a. State 10b. County			y, Town or Lo		- "						1	0d. Inside City Limits	
T.	r 28e-	Director	Maryland  10e. Street and Number		Bal	ltimoı	10f. Zip	Code				10.0			1 X Yes 2 □ No	
0	23e o	Funeral	1408 Riggs Ave	enue			212					USA	itizen of W	nat Coun	try?	
<i>C.</i>	death Items		11. Marital Status	12. Was Decede	252		Vas Deced	ent of Hi	spanic Oni	gin? (Spe	cify Yes or No Rican, etc.)	-	14. Race			
Z7215-0036	permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Whether with an end filed a strength of the marked other then "naturel", or items 23e or 28e-f show eny injury or other treumatic event, the Medical Examiner must be notified at once.	Completed by	1 ☐ Never Married 2 ☐ Married 3 🗶 Widowed 4 ☐ Divorced	1  Yes 2 If Yes, Give Year or Date	IX No		☐ Yes			kican, Puerto Rican, etc.)  Specify:  Sp				Black, White, etc. pecify: Black		
15-	72 ho on "nat Medic	mple	15. Decedent's (Specify only highest g	grade completed)	- 7	16a. Deced (Give	lent's Usua kind of wor O NOT use	k done d		t of worki	ng	16b. I	Kind of Bus	siness/Inc	dustry	
<b>3</b> 5	within giene. er the t, ine	ပို	Elementary/Secondary (0-12)  3rd grade	College (1-4	or 5+)	Cook		1011100)				Re	stau	ran	rant	
	e filed ntal Hy ed oth	To Be	17. Father's Name (First, Middle, Last,								(First, Middle		,			
Maryl	ouid b d Mei mark matic		Henderson John 19a. Informant's Name/Relationship (			10h Mailie	a Address				Ann Da			ata Zin C	'adel	
7/2	nd 2 sh saith a n 27 is er treu		Johnnie Sue Co		hter		-					-			nd 21217	
Baltimore,	ge 1 er it of He if iter or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [	Removal from St	tate C	lace of Dispo emetery, crer	natory or o	her place	e)		Date	1	_ocation - (	•		
<b>₩</b>	nit. Pag artmen ortent: injury		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice		Ced										Maryland ral Home	
$\mathcal{P}_{\mathbf{a}}$	Depar Impor eny ir		21. Signature of Fullerial Service Elder	Valo											ID.21215	
$\circ$			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	mplications that cau	used the deatl	h. Do not ente	er the mode	of dying	g, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between	
P	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a	0/04	1 00	M	2	r						Onset and Death	
3	Examiner			Due to (or	as a consecu	uence of):										
4	+	iner	Sequentially list conditions, if any, leading to immediate cauco. Enter Underlying	b. Due to (or	as a consequ	uence of):										
67	executed ian and urial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequ	uence of):										
50	g			■ d												
288	een cennicate be attending physici d for use as the bu	Physician/Medical	IF FEMALE:	23c. If yes, outco	me of pregna	nev									<del></del>	
	he atten	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Bir 4 ☐ Pregna	rth 2 ☐ Feta ntat time of c	I death 3	Ectopic p Other (sp		у				23d. Date Mon		ery Day Year	
₹.	trine der d by the a etached	Phys	9 ☐ Unknown  Part II. Other significant conditions	9 Unknov	_	ulting in the u	ndodvina	auna aiu	on in Bost		T			/		
20.	requires that the been signed by the should be detach	d by	DIANOS	A Continuous to dea	ui but not res	alang in the t	ndenying c	ause giv	enmran				/		e cause of death?	
		Completed by	1/1/1/7								24a. Was		246. W	ere autor	osy findings available	
25 E	ate ha page 2	Som	11011							-	per	opsy formed? 2	<b>∕</b> 1 de	or to cor eath? □ Yes	npletion of cause of	
ital Records,	rnysicien: the law this certificate has b ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:				Otho	ace of Dea	th (Check	_		/		1/12 -10	
<b>\$5</b>	arthis eral di	e: 10	1 ☐ Yes 2 D No 27. Man r of Death	28a. Date of		28b. Time of		Bc. Injury	4 ∐ Nu rat		me 5 Res 28d. Describe				1909 PIL	
30	eath. or: After the fune	ficat	1 Natural 5 Pending 2 Accident Investigati 3 Suicide 6 Could not	on	Day, Year)	injury	М	work	? Yes 2□	No						
	after d after d Direct	Certificate:	4 Homicide determined	28e. Place of	Injury - At ho , etc. (Specify		et, factory	office			28f. Location City or To			or Rural	Route Number,	
. 🗀	uio une nospitei or Attending Fry within Z4 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	(Check 2 Medical Exar	nysician: To the bes miner: On the basis	of examination	and/or inves	tigation, in r	ny opinio	n, death oc	curred at	the time, date	and place	e, and due	to the cau	ise(s) and manner stated,	
į	vithin 2 within 2 To the comple	Σ	only one 3 Certifying Nu 29b. Signature and title of certifier	rse Practitioner: I	o the best of n	ny knowledye			number	Vs-and pla	nie, and due to		e(s) and ma	,	/	
			MAIN N	Mama	0/1			2/	30,	12/	/		10/19	4//	2	
	A		30. Name and id ress of person who	compled cause	ol de ath (Item	23-4 Type	rint)	05	51	Bo	Ito	M	1/4	2/2	18	
	Stat Registra	te ar	31. Date filed (Month, Day, Year) 0CT 2 2/2012	32. Reg	istrar's Signat	ture	0				1	- /	•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🕦 📗 33840 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Herbert Spencer Wright Sr. : 20 PM 2012 Medical 10 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care Woodbridge Valley Baltimore Catonsville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. 213-68-2432 Director 1**X** M 2 □ F 56 10/09/1956 Maryland ?7 is marked other than "naturai", or items 23a or 28a-f shov traumatic event, <u>the Medical Examiner must be notifled at</u> 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Baltimore Gwynn Oak 1 🗆 Yes 2 🖺 No 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country? 21207 3710 Cedar Drive USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force 1 X Never Married 2 ☐ Married Black, White, etc. ģ 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: Black Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Private Industry 12th grade Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vern Wright Elvie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Verna Mason/Sister 1133 Dorchester Ave. Gwynn Oak MD. 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10/20/12 1 Burial 2 Cremation 3 Removal from State St.Luke UM Church Cemetery 4 □ Donation 5 □ Other (Specify) Hereford, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee uller ars 5240 Reisterstown Rd.Baltimore, MD. 21215 Ô 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HUMAN IMMUND DEFICIENCY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to for as a consequence off Hospital or Attending Physicien: The law requires thet the death certificate be executed use as the burial-transi Cause (Disease or injury that initiated events the attending physician and thed for use as the burial-tran Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by within 24 hours after death.

To the Funeral Director: After this certificate has been siy completely filled in by the funeral director, page 2 should I 1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? မြ 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in intropolation, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 5059107 10-16-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUSINESS CENTER DRIVE REISTERSTOWN, MD 21136 UMA 31. Date filed (Month, Day, Year) OCT 2 2 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1119 Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death Baltomore HOPKIAS HOSPITAL n/a If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours Director NONE 1 □ M 2**X** F Dec 13, 1950 China Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Director 1 X Yes 2 □ No Shaanx n/a Xian, China 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral No. 1 Street, Xinan Village 7/0115 China 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 Yes 2 X No Specify: 3 Divorced Specify: Asian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Farmer Farming 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Xin Aigin Zhang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3066 Southern Elm Ct., Fairfax, VA 22031 Liya Wang-daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 1 Burial 2 Cremation 3 Removal from State Important: If any injury or once. 10/22/12 Towson, MD Hilltop Serv Corp 4 Donation 5 Other (Specify) 21. Signature of Fungeral Service Liefensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition resulting in death) Medical CHRITIFICATION APPROVED BY NIEDICAL EXAMINER Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Pes 2 No
9 Unknown Month 5 Other (specify) Day To the Hospital or Attending Physician: The law requires that the ueat within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Yunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 2 🗆 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) (0 - 14 - 2012 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Accident 5 Pending work? 1 ☐ Yes 2 ☑ No 4:00 P.M consumption of amanita Phalloides Investigation 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 3006 Southern Elm Ct, Fairfax Medical 29a. Certifier 1 of Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1800 N. Orleans St. Battimore SARINA

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#5,20a,b,perFH,6933,11/1/2012,WS

State of Maryland / Department of Health and Mental Hygiene 33842 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Octobe My 1120 AHMAD ELIJAH WHEATLEY 01:25AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Ai HOSPITAL ALTIMORE 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Hours Months Min (Month, Day, Year) **Director** 1**火** M 2 □ F 6 Yrs. FEB 5 2006 MD Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits or 28a-f 1 X Yes 2 No MD NA BALTIMORE 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? iral", or items 23a Examiner must be Funeral 3903 HILTON ROAD 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced If Yes, Give "natura!" Specify: BLACK Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) if of Health and Mental Hygiene.
If item 27 is marked other than or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) STUDENT SCHOOL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ERIC LOCKETT DWANISE WHEATLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 shit of Health a 3903 HILTON ROAD DWANISE WHEATLEY - MOTHER BALTIMORE, MD 21215 20a. Method of Disposition Ukn 20b. Place of Disposition (Name of T) cemetery, crematory or other prace) Date Ukn 20c. Location - City or Town, State 1 Burial 2 🙀 Cremation 3 🗌 Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) 10/24/2012 Metro Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4300 WABASH AVE MARCH FUNERAL HOME WEST 21215 BALTO., MD 23a. Part 1. Enter the di ease, or complications that caus should, or heart hailtre. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Immediate Cause (Final OCEREBELLAR ATAXIA Onset and Death Physician/ disease or condition LOV Medical resulting in death) Due to (or as a consequence of): **Examiner** 4 POXI routh Sequentially list conditions, Examine a consequence of) if any, leading to immediate cause. Enter Underlying (or sician and burial-transit 101 Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Month Day Year 2 No 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by NUTRITION Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed DIFFICULTIES 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼ No 24a. Was an autopsy performed? Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 1 🗆 Inpatient 2 📉 ER/Outpatient 3 🗔 DOA this 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pending injury within 24 hours after death To the Funeral Director: A Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Spital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatu and title of certifier 29d. Date signed (Month, Day, Year) UCTOBER 2017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL BALTIROKE SINAI Year) Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Geraldine Williams 09:20 AM tober Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Glen BUrnie Baltimore Washington Medical Ctr Anne Arundel . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 219-30-5597 77 1 □ M 2 🔏 F Director 11-22-34 Kentucky Usual Residence of Decedent of Health end Mental Hygiene. item 23e or 28e-f show item 27 is marked other then "naturel", or items 23e or 28e-f show other traumatic event, the Medical Examination in 1st be marticed at 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Glen Burnie 1 Yes 2 No 10e. Street and Number 10f. Zîp Code 10g. Citizen of What Country? 504 Theresa Avenue 21061 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 ☐ Yes 2 X No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify white 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home maker Home Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Theodore Givens Ruby Lucille Williams Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health en Importent: If item 27 is 1 eny Injury or and Evelyn Herron / friend 123 5th Ave SW Glen Burnie MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Glen Haven Memoria Pk 10/24/12 4 Donation 5 Other (Specify) Glen Burnie MD 21. Signatur (Eurlaral Sec Licensee 22. Name and Address of Facility  $^{22.\,\text{Name}}$  and Address of Facility  $\,$  Kirkley Ruddick Funeral Home  $\,$  421 Crain Hwy S Glen Burnie MD  $\,21061$ M01364 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pheumoni Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Emphyen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as consequence of) siclan and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ٰا 1 2 Yes Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) ᅆ 1 Dinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No Natural 5 Pending 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ctober 10073466 2012 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIMD DAGOBERT 301 Hospital drive glen burnie mo 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5, per fn, 8933 11-2-17 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ atin Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1<sup>3</sup>7 Sec 3<sup>5</sup>2 0486 Birthplace (State or Foreign Country) Hours Director 94 Yrs. 1 X M 2 □ F 10/17/1918 OH 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be nutflied 1 Yes 2X No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 9262 HOWARD SQUARE DRIVE 21208 USA death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian à Black White etc. 1 Never Married 2 X Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Divorced Specify: WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) MARYLAND DISPLAY Elementary/Secondary (0-12) College (1-4 or 5+) COMMERCIAL ARTIST SERVICE other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F မ Page 1 and 2 should be ZLATIN TDA GORELICK of Health and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARSHA LAUFER/DAUGHTER 1750 S. OCEAN BLVD., MANALAPAN, FL 33462 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ō Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) COLUMBIA MEMORIAL PARK 10/19/2012 COLUMBIA, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. ellel 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final End-Stage Cardiomyopath Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burlal-transi Cause (Disease of injury that initiated events resulting in death) Last P.O. Box 687606 Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2: autopsy 2 1 No ☐ Yes 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Certificate: To Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier MS ICEN WALL 29d. Date signed (Month, Day, Year) D0057465 10/18/12 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar NSPAJAPAKEMO

5753

7835 Smith W

32. Register's Signature

Baltimoremo 7,204

2-07480 Sherwood Adams		Please Type or Print in Black Indelible I  State of Maryland / Department o  Certificate o	f Health ar			jible. 201	2 3381			
Physician	n/	Registrar  1. Decedent's Name (First, Middle, Last)  Sherwood Adamson	i Dealli	<u></u> .	Date of Death     Month	g. No. n Day Year	3. Time of Death 2145 hrs			
Medical Examin	e i	4a. Facility Name (if not institution, give street and number)  Southern Maryland Hospital	Clinton	or Location of Dea		4c, County of Deat Prince Georg	h e's			
Funeral Director		5. Social Security Number 577-94-1485 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 49 Yrs  Usual Residence of Decedent	Months Da			1963 Co				
Aaryland 28a-f show any .at once.		10a. State D.C.  10b. County D.C.  Washing			110	lg. Citizen of What Cou	10d. Inside City Limits 1 Yes 2 No			
h the Mary 3a or 28a	I Director	808 55th St., N.E.	20019	9	U.S.A.					
	by Funeral	Armed Forces? If \( \)  Never Married 2 Married 1 Yes 2 \( \) No   Yes 2 \( \) No   Yes 5 \( \) No   Yes 5 \( \) No   Yes 2 \( \) No   Yes 2 \( \) No   Yes 2 \( \) No   Yes 2 \( \) No   Yes 2 \( \)	Yes, specify Cuba	an, Mexican, Puer o specify:		White, etc.  Specify: B	lack			
036 thin 72 hours ne. than "natur ledical Exam	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		ation (Give kind o ie. DO NOT use re		16b. Kind of Business,	Industry  None			
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	S B C	17. Father's Name (First, Middle, Last) Sherwood Kincaid Adamson, Sr.			ne (First, Middle, M ene M. Br					
MD 212 d 2 should be lith and Ment m 27 is mark	٩	19a. Informant's Name/Relationship (Type, Print)19b. MailinDenise Lancaster/Sister6207	Welshire	e Pl.,Up	per Marlb	per, City or Town, State	772			
Baltimore, permit. Pages 1 an Department of Hea Important: If iter injury or other tra		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Dispocrematory or of Harmony M	s 10,	Date /18/12	20c. Location - City o	Maryland				
Ball permit Depar Impor		21. Signature of Funeral Service Licensee  CC 0316  22. Signature of Funeral Service Licensee  49	Henry 2 25 Burro	s Washi Sughs Ave	ngton & S e.,N.E.,W	ons Co.,In Jashington,	C. D.C. 20019			
Physician /Medical Examiner	Î	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  a. Intracerebellar Hemo  Due to (or as a consequence of):  b.  Due to (or as a consequence of):		g, such as cardiac	c or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death			
executed an and al - transit	Examine	u.								
O,  be exected a sister of the sected and sister of the sected and sister of the sected and sected	edical	✓ UNPENDED ☐ AMENDED 23a,pt.II,27,p	er me,g	932 10-24	4-12 sm					
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		past 12 months?	etal death 3 ther (Specify)	Ectopic preg	nancy	23d. Date of deliver	y Day Year			
p, P.O. ires that the signed by a detached		Part II. Other significant conditions contributing to death but not resulting in the Cocaine and Phencyclidine Use	underlying cause	given in Part I.	1 Yes		the cause of death? bably 4  Unknown			
Records The law requ ficate has beer	Completed by				24a. Was a autops perform 1 ✓ Yes 2	sy prior to med? death?	utopsy findings available completion of cause of es 2 No			
Vital ysician:	8 2	25. Was case referred to medical examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatien		Other Nurs		Residence 6 Othe	нг: 			
ion of tending Pheath.	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		ury at Work? Yes 2 No	28d, Describe h	ow injury occurred				
Divis  To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined (Specify)		-	or Town, St	ate)	ural Route Number, City			
o the Ho ithin 24 o the Fu	Medical	25d. Certifying Physician: To the best of my knowledge, death occur one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.								
F 3 F 8	Me	29b. Signature and title of certifier Patricular Pollular		se number		29d. Date signed (Mo				
		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner		imore Street,	Baltimore, MD	21223				
Sta Registr		31. Date filed (1/port), Apy, Yaa 2012 42. Registrar's Sign ture								

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day 8:48 P M Lucy Mary Brewer 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1/01/1919 213-16-2861 **Director** Virginia Usual Residence of Decedent f show 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Churchton Maryland Anne Arundel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5557 Franklin Blvd. 20733 United States 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify Completed 3 👿 Widowed 4 🗆 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Gould Electronics <u>Parts Assembler</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Walter Lewis Lucy Anne Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Mullican/Nephew 13820 Drake Drive, Rockville, Maryland 20853 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Page 1 cemetery, crematory or other place 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 10/03/2012 Edgewater, Maryland Signatur Funeral ervice Lice 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Dav Year 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part الـ **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 2 No 1 Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 🗌 Yes 2 No 1 Unpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

vd

(Check

only one

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature back

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

4337

AMMIC

29d. Date signed (Month. Day, Year

29c. License number

		Ple	ease Type or Pri	int in Bla	ck Ind	delible Inl	k. Ensure	All Copie	s Are L	egible.	
		For State Registrar		aryland /	Depar <i>Certi</i>	tment of F ificate of L	Health and Death	d Mental Hy	giene 2 Reg. No.	012	33847
Physicia		Decedent's Name (First, Midel     Rhoda Deborah	· - •					2. Date of De Month Octob	er 4,	201 <sup>9</sup>	3. Time of Death 5:50 A M
Medic Examin		4a. Facility Name (if not institution	on, give street and number)		4	4b. City, Town, o	r Location of De			unty of Death	1 3.30 A ···
-		WMHS-Frostbur  5. Social Security Number		Rehab Ce		Frostl	ourg			legany	
Funeral Director		413-34-3399	1 M 2 X F	87		Months Days	Hours Mi		y Year 2, 192	4 F10	place (State or Foreign htry) rida
at	'n	Usual Residence of Decedent 10a. State 10b. Coun	ty	10c. City, Tow	vn or Locat	tion				T	10d. Inside City Limits
28a-f s	Funeral Director	MD Garre	ett	Grant	tsvil	le					1 🛣 Yes 2 □ No
3a or	ralD	10e. Street and Number	7	- 116		10f. Zip Code			-	of What Cou	ntry?
ems 2	nue	25 N. Pennsylv	12. Was Decedent I		13. Wa	21536 s Decedent of Hi	ispanic Origin? (	Specify Yes or No-	USA	A Race - Americ	can Indian
", or if	۵	1 Never Married 2 M	If Von Cive	No	If Y	es, specify Cuba ☐ Yes 2 🎛 No	in, Mexican, Pue	erto Rican, etc.)	'"	Black, White,	etc.
natura ical Ex	letec	3 🔀 Widowed 4 🗌 Divorce	ed Year or Dates.  dent's Education	16a		nt's Usual Occup					ite
han "r e Med	Completed	(Specify only hig Elementary/Seconday (0-12)	hest grade completed)	5+)	(Give kin life. DO I	d of work done c NOT use retired)		rorking		of Business In	dustry
Hygier other t	Bec	17. Father's Name (First, Middle		Ho	omema	Ker	10 Matharia N	lama /Finsk & findula		n Home	
Mental arked aric ev	흔	Clem Clark Gri					Bannie	lame (First, Middle, Hall	iviaiden Surr	name)	
7 is ma rauma		19a. Informant's Name/Relation						Rural Route Numbe			Code)
Healt item 2 other 1		Ernest J. Durs 20a. Method of Disposition	t/Nephew			Stardrii	Et Dr.,	Germanto		0 2087	
nent o		1 Burial 2 X Crematio 4 Donation 5 Dother	n 3 Removal from State (Specify)	cemete	ery, cremat	ory or other plac		ct. 4, 20		-	
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Ollra Ole	1	22. N	lame and Addres	ss of Facility N	Newman Fu	neral	Homes,	
		23a. Part 1. Ent a the disease,	or complications that caused	the death. Do				antsville		21536	Approximate
ysician/		shock, or heart failure. List Immediate Cause (Final disease or condition	t only one cause on each line	€.							Interval Between Onset and Death
Medical xaminer		resulting in death)	Due to (or as:	a consequence	of):		p 2011	G DISEA.	3/~		
	ner	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a consequence	of):						
and I-transit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events c.									
cian ar ourial-t	- 1	resulting in death) Last	Due to (or as	a consequence	of):						
physi sthet	Physician/Medical		d								
r use a	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live Birth	of pregnancy	th 3∏ E	ctopic pregnanc	v		23d	. Date of deliv	ery
the att	ıysici	1 Yes 2 No 9 Unknown	4 ☐ Pregnant a 9 ☐ Unknown			other (specify)				Month	Day Year
ned by detac	Z P	Part II. Other significant condit		ut not resulting	in the und	erlying cause giv	en in Part I.	23e, Did to	bacco use c	ontribute to the	ne cause of death?
en sig	ted k	DE.	MENTIA					_ 1 🗆 '	Yes 2 \( \int \)	lo 3 🗆 Pro	bably 4 Unknown
has be	Completed by							24a. Was autop	sy	prior to co	psy findings available mpletion of cause of
ificate or, pag	ပ္ပို	25. Was case referred to medica	al			00 Di		1 \sum Yes	rmed? 2 No	death?	2 🗌 No
is cert direct	10 B	examiner? 1  Yes 2 No	Hospital:	ent 2 ER/O	utpatient	Otho	er: We Nursing	Home 5 Resid	lence 6 🗆	Other (Specify	)
h. After ti funera	ate	27. Manner of Death  1 ☑ Natural 5 ☐ Pend			Time of injury	28c. Injury work	at?	28d. Describe h			· · · · · · · · · · · · · · · · · · ·
ector. by the	Certificate:	3 Suicide 6 Coul	mined 28e. Place of Inju	ıry - At home, fa	arm, street,		Yes 2 No	28f. Location (S	treet and Nu	mber or Rural	Route Number
urs afte ral Din lled in l			building, etc	c. (Specify)				City or Tow	n, State)		
within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	Medical	(Check 2 L Medical	ng Physician: To the best of Examiner: On the basis of examiner: To the	xamination and/o	or investiga	ition, in my opinio	n, death occurre	d at the time, date a	nd place, and	I due to the car	ice(s) and manner stated
within To the compl		only one) 3 $\square$ Certifyir 29b. Signature and title of certifi	ng Nurse Practioner: To the	Dest of my know	vieage, dea	29c. License			29d. Date sig	gned (Month, I	Day, Year)
			Hadh			1121	5907	T	DUTO	BER C	142012

State Registrar

30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)

Dr. Harjit Sidhu 925 Bishop Walsh Rd

31. Date filed (Month, Day, Year)

OCT -5 2012

32. Registrar's Signature

OCT - 5 2012

Cumberland MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33848 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 20°12 Edwin T. Brown 3:23 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8247 George Washington Highway Oakland Garrett If Under 1 Year | If Under 24 Hrs. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country Months Days Hours (Month Day 1 Year) Director 236-03-8215 1 M M 2 🗆 F 93 ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No MD Oakland Garrett 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 8247 George Washington Highway 21550 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced 1943 - 1945 White Year or Dates. 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Foreman Lumber 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mentai H . Page 1 and 2 should be fill tment of Health and Mental tant: If Item 27 Is marked o Frederick Fulton Brown Mary Rumors 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dale Brown / Son 8283 George Washington Highway, Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō Department of Important: If eny Injury or once. 4 Donation 5 Other (Specify) 10/6/2012 Bayard, WV Bayard Cemetery Signature of Funeral Service License 22. Name and Address of Facility Burdock-Fredlock Funeral Home, P.A. 21 North Second Street, Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Coronary Artery Disease Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events Due to (or as a consequence of) • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Pregnant at time of death Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 2 🔀 No ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural
Accident
Suicide injury 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined cal 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fil 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0031674 10/4/2012 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey Berstein, MD 1027 Memorial Drive Oakland, MD 21550 31. Date filed (Month, Day, Year) Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month :01 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PG TAKOMA PARK WASHINGTON ADVENTIST HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Country) Director 579-10-9831 1 🗆 M 2 🛛 F Yrs. 6-2-1914 DC 98 and Mental Hygiene. Is marked other then "neture!", or items 23e or 28e-f show reumetic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No PG HYATTSVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3900 HAMILTON STREET #G104 20781 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♠ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK Completed 3 X Widowed 4 ☐ Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE 12TH DOMESTIC other treumetic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pege 1 end 2 should be file Depertment of Heelth and Mental I Important: if item 27 is marked c any injury or other treumetic eve ည ROBERT TAYLOR MARY HUMPHREY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VERONICA E. BYRD/DAUGHTER 3900 HAMILTON STREET, #G104, HYATTSVILLE, MD 20781 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State RESURRECTION CEMETERY 10-6-2012 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CLINTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility PUFE FUNERAL HUMES, P.A. 21. Signature of Funeral Service Licensee M0098 Harle 538 MARLBORO PIKE, FORESTVILLE, 20747 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only do cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): e Hospitel or Attending Physicien: The law requires that the deeth certificate be executed nows efter death.

• Funerel Director: After this certificate has been signed by the ettending physician and sietely filled in by the funeral director, page 2 should be detached for use es the burlel-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ Completed 1 Yes 2 No 3 Probably 4 1 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ▼ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Inpatient 2 I ER/Outpatient 3 I DOA မ 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined cal 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fl (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of o 29c. License number 29d. Date signed (Month. Day, Year)

Registrar
DHMH 17 Rev 06-2011

ZJM

State

30. Name and address of p

31. Date filed (Month, Day,

SMIT

YYL.

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Joan Levy Burka  $P^{M}$ October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Rockville Nursing Home Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) 8. Date of Birth Days Hours Min. (Month, Day, Year) Director 579-46-8575 1 □ M 2 🛛 F 79 10/25/1932 Washington, DC Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits within 72 hours after death with the Maryland Director Chevy Chase Maryland Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a United States 5401 Uppingham Street 20815 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 6 1 Never Married 2 Married ğ Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates "natural", Completed 3 ☐ Widowed 4 🏋 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o permit. Page 1 and 2 should be fill.
Department of Health and Mental |
Important: If Item 27 is marked c ည Anne Cason S. Frank Levy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard L. Burka / Son Outpost Drive North Potomac, MD 20878 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State National Crematory Falls Church, VA 4 Donation 5 Other (Specify) 10-5-2012 Signature of Faneral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons LLC. Man CC0379 5130 Wisconsin Avenue NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysiciani End Stage Chronic Obstructive Pulmonary Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying r use as the burial-transit Cause (Disease or injury that initiated events The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours. fer death.

To the Funeral Director After this certificate has been signed by the attending physician. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗓 No Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2X N 1 ☐ Yes 2 🛛 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Sunitha Bhogavilli,

04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

DHMH 17 Rev 06-2011

29c. License number

D0054566

M.D. 9801 Georgia Avenue Suite 1-17 Silver Spring, MD 20902

29d. Date signed (Month, Day, Year)

10/02/2012

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep State wchd/amend item #20b/te/10-05e	partment of Health an					
			1. Decedent's Name (First, Middle, Last)	MAICALE OI DEALII	Reg 2. Date of Death	. No. 20	<del>2 , 3 3 8 5 1</del>		
	Physicia		John Franklin Baughman, Jr.		Month /O	Day Year			
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of D		4c. County of Dea	ath		
	<i>)</i>		Peninsula Regional Medical Center	Salisbury		Wicom	uico		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,		Hrs. 8. Date of Birth  Min. (Month, Day, Ye	9. B	irthplace (State or Foreign ountry)		
	Director		495-58-7815   1XD M 2 □ F   Yrs. Usual Residence of Decedent   60		10-08-1	951 CA			
	shov	tor	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits		
	Mary 28a-f	irec	MD Wicomico Salisbu	ry			1 ☐ Yes 2 🌠 No		
	th the	alD	10e. Street and Number	10f. Zip Code	100	g. Citizen of What C	Country?		
	ms 2	Funeral Director	29339 Naylor Mill Road  11. Marital Status 12. Was Decedent Ever, in U.S. 13	21801		JSA			
(O	or ite	by Fi	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces? A i r F or C i No i Nover Married 2 Nover Mar	. Was Decedent of Hispanic Origin? ∰ Yes, specify Cuban, Mexican, Pu	r (Specity Yes or No- uerto Rican, etc.)	14. Race - Am Black, Whi			
8	ırs aft ıral",	edt	3 Widowed 4 Divorced If Yes, Give Year or Dates 1 9 6 9 - 70	1 ☐ Yes 2X No Specify:		SpecifyWhi	.te		
5	"natu	Completed		edent's Usual Occupation e kind of work done during most of	working 16	b. Kind of Business	s/Industry		
<del>7</del>	thin 7	E O	Elementary/Secondary (0-12) College (1-4 or 5+) life.	DO NOT use retired)		Cold Wat	er		
D D	Hygiw other ent,	Be (	17. Father's Name (First, Middle, Last)	eworker	Name (First, Middle, Mai	Seafood den Sumame)	<u> </u>		
Baltimore, Maryland 21215-0036	dental dental rked tic ev	잍	John F. Baughman, Sr.		red R. Wri				
a٦	should and N is ma			ling Address (Street and Number or	Rural Route Number, Ci	ty or Town, State, Z	<del></del>		
Σ	ealth m 27			39 Naylor Mil.	l Rd, Sali	sbury,	MD 21801		
ore	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 X Burial 2 ★ Cremation 3 ☐ Removal from State	osition (Name of ematory or other of action	Date 20	c. Location - City o	r Town, State		
Ħ.	it. Pac rtmer rtant njury		4 Donation 5 Other (Specify)	matory or other page TERY Cromation 10	<u>-5-2012 Ні</u>	ırlock,	MD		
Ba	Depa Impo any i		21. Signature of Funeral Service Licensee	22. Name and Address of Facility9 ennie Smith	17 W. Isak	pella St	. 1		
			23a. Part 1. Enter the disease, or complications that gaused the death. Do not er	uneral Home Sater the mode of dying, such as care	diac or respiratory arrest,	MD ZIOC	Approximate		
-	nysician/		snock, or neart failure. List only one cause on each line.				Interval Between Onset and Death		
	Medical		disease or condition resulting in death)  a. Due to (urins a consequence of):	140 (2V					
	Examiner	,	Sequentially list conditions, b.						
7	sit of	nine	if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):						
	and and II-tran	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):						
0	cate be executed physician and s the burlal-transit	edical	L <sub>d</sub>						
3760	ficate g phy as the		_ u.						
× 68	h cert tendin or use	Physician/M	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Live Birth 2 ☐ Fetal death 3	Ectopic pregnancy		23d. Date of de	elivery		
Records, P.O. Box	deat the att	/sici		Other (specify)		Month	Day Year		
Ö.	at the	P.	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e Did tobac	co use contribute t	o the cause of death?		
S,	signe signe d be	٩			1		Probably 4. Unknown		
ord	v requ	Completed by			24a. Was an		utopsy findings available		
ě	he lav te has age 2	E			— autopsy performe	prior to	completion of cause of		
a F	ian: Ti rtifica ctor, p	BeC	25. Was case referred to medical examiner?	26. Place of Death (C		Noj 1∟JYe	s 2 No		
Ĭ	hysici his ce	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Other: 4 Nursin	ng Home 5 🗆 Residenc	e 6 🗌 Other (Spe	cify)		
٥	ling P	ate:	27. Magner of Death  1. Natural 5 □ Pending  28a. Date of injury (Month, Day, Year)  28b. Time of injury injury	work?	28d. Describe how i	njury occurred			
Sior	death death stor: / y the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No					
Division of Vital	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	S	4 ☐ Homicide determined 286. Place or injury - At nome, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S		ural Houte Number,		
_	ospita hours uneral	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and plan	ce, and due to the cause	(s) and manner as s	stated.		
	the H hin 24 the Fi nplete	¥ ¥	(Check 2  Medical Examiner: On the basis of examination and/or inve only one) 3  Certifying Nurse Practitioner: To the best of my knowledg	stigation, in my opinion, death occurred at the time, date ar	red at the time, date and p nd place, and due to the c	lace, and due to the ause(s) and manner	cause(s) and manner stated. as stated.		
	e 美 e g		29b. Signature and title of certifier	29c. License number		. Date signed (Mont			
			7 Gnyg Cl. Hard (RND) 30. Name and address of person who completed cause of death (Item 23a) (Type,	R15377	6	10-7-	12		
	11/2.		30. Name and address of person who completed cause of death (Item 23a) (Type, TANYA CIIIFOID CAMP 100 E	Print) CARROII ST.	SAUSBUR	no			
	Stat Registra	e	31. Date filed (Month, Day, Year) 2012 33. Registrar's Signature	a Ked					
	riegistie	4	p. 19.11	Of the second					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0948 AM 201 Medical Examiner 4a. Facility Name (if not institution, give street and number or Location of Death 4c. County of Death it Mary and MOMOL Social Security Number 6. Sex If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Months Min (Month, Day, Year) 212-70-4957 **Director** 1 M 2 XF 56 08/18/1956 MARYLAND Usual Residence of Decedent or 28a-f show ould be filed within 72 hours after death with the Maryland to Mental Hygiene.
marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No QUEEN ANNE'S CHESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2639 COX NECK ROAD 21619 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give 3 Widowed 4 Divorced Specify: WHITE Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 6 ROBERT FRANKLIN GIBBONS MARY WARD I and 2 should by Health and Meinten 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RONALD E. CATTERTON / HUSBAND 2639 COX NECK ROAD, CHESTER, MD 21619 or other Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CHESAPEAKE CREMATION 10/03/2012 permit. Page 1 Department of Important: If it any injury or o 1 🗆 Burial 2 ဳ Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 21. Signa r of Funer FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one caus Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and-trar Due to (or as a consequence of): burial attending physician Physician/Medical that the death certificate be Box 68760 as the IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 Fetal death in the past 12 months? Ectopic pregnancy for Month Day Pregnant at time of death ed by the a detached i 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Records, or Attending Physician; The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autonsy page perform death? certificate 2 No Yes 2 of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, ျပ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer (Month, Day, Year) 1 Natural 5 Pending Division 1 Yes Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one nd title of certifie 29b. Signatu 29d. Date signed (Month, Day, Year) 88 2012 01 MS nd address of pe on who completed cause of death (Item 23a) (Type, Print) South Cu 32. Registrar's Signature State

DHMH 17 Rev 06-2011

State

Registrar

LOUIS J. MOYER, MD

OCT 0 4 2012

31. Date filed (Month, Day, Year)

32. Registrar's Sig lature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALTER REED NATIONAL MILITARY MEDICAL CENTER

BETHESDA, MD 20889

			Plea	ase Type or Pri	nt in E	Black	Indelible In	k. Ensure	All Copie	s Are	e Legible		
			For State	State of M	arylan		partment of		Mental Hy	/giene	•		0071
	_		Registrar  1. Decedent's Name (First, Middle	e, Last)		C	ertificate of	Death	2. Date of D	Reg. No	0. 201	2 3 Tim	3854 e of Death
	Physicia Medic		Ronald Ray D						oct.		2012 <sup>Year</sup>		:15p M
)	Examin		4a. Facility Name (if not institution 3690 Hutton	-			1	or Location of Death	1	40	County of Dea		
./ 	Funeral		5. Social Security Number	6. Sex 7. Ag	je (In yrs. la	st birthda	y) If Under 1 Year		8. Date of Bi	irth	Garre 9. Bi	rthplace (Sta	te or Foreign
	Director		213-64-9709 Usual Residence of Decedent	1 <b>X</b> M 2 □ F	60	Yrs	Months Days	Hours Min.	Dec 6	ay, Year)	951 Ma	rylar	d
and	show d at	tor	10a. State 10b. County			, Town or						10d. Insid	e City Limits
e Mary	r 28a-f notifie	Director	MD Garrett Oal										Yes 2 X No
with the	23a or		10e. Street and Number 3690 Hutton	Road			10f. Zip Code	1550		_	itizen of What C USA	ountry?	
death v	items ner mu	Funeral	11. Marital Status	12. Was Decedent   Armed Forces?	Ever in U.S	. 1	3. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Sp	ecify Yes or No	<u> </u>	14. Race - Am		1,
safter	Department of Health and Mential Hygiene. Important: If item Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by	1 ☐ Never Married 2 🙀 Mar 3 ☐ Widowed 4 ☐ Divorced	ried 1 Yes 2 X	No 1 ☐ Yes 2 【XNo Specify:						Specify: white		
2 hour	"natur	Completed	15. Decede (Specify only high	nt's Education est grade completed)			cedent's Usual Occu		kina	16b. Kind of Business Industry			
rithin 7	r than	Com	Elementary/Seconday (0-12)	College (1-4 or	(5+) Iffe. DO NOT use retired)  Carpenter				Ca	Carpentry			
filed w	al Hyg d othe event,	Be	17. Father's Name (First, Middle,	· ·			Pencer	18. Mother's Nan		, Maiden	Surname)		
uld be	d Ment marke natic	To	Herbert Will								ia Rec		
12 sho	alth an 27 is i		19a. Informant's Name/Relations  Jean L. DeWi				ailing Address (Stree Box 402			-	r Town, State, Z 26764		
e 1 and	of He		20a. Method of Disposition  1 XBurial 2 Cremation	3 Removal from State		ace of Dis	sposition (Name of crematory or other pla		Date		ocation - City o	r Town, State	€
it. Pag	rtment rtant: njury c		4 Donation 5 Other (	Specify)	Gai	ret	t Co.Men						
perm	Impo any ir		21. Signature of Fundal Service	) Leurnau	)			ess of Facility Ne 2nd St.,				•	P.A.
П			23a. Part 1. Enter the disease, or shock, or hear failure. List			. Do not e	enter the mode of dy	ing, such as cardiac	or respiratory a	ırrest,			Between
	/sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. OPL Due to (or as	2 22222	once of						Onset a	nd Death
Ex	aminer		Sequentially list conditions,	b	a oonooqa	01,00 0.7.							
pe	sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as	a consequ	ence of):							
executed	□ 10	Еха	that initiated events resulting in death) Last	C. Due to (or as	a consequ	ence of):							
		dica		d									
certifica	s attending physicia d for use as the buri	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of de	eliverv	
death	he atte ed for	Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown			3 ☐ Ectopic pregnar 5 ☐ Other (specify)	ncy			Month	Day	Year
nat the	ed by ti	/ Phy	Part II. Other significant conditi	ons contributing to death b	out not resu	ulting in th	ne underlying cause o	given in Part I.	23e. Did	tobacco	use contribute t	o the cause	of death?
uires t	en sign uld be	ed by	1   Yes 2   No 3							Probably 4	Unknown		
law red	as ber e 2 shc	Completed							24a. Was	psy	24b. Were at	utopsy findir completion	gs available of cause of
n: The	ificate l		25. Was case referred to medical				26.1	Place of Death (Chec	1 Tes	formed? 2 XN	death?	s 2 🗆 No	-
nysicia	iis cert directo	To Be	examiner? 1 Yes 2 XNo	Hospital: 1 ☐ Inpat	ient 2 🗆 I	ER/Outpa		hor		idence 6	6 ☐ Other (Spe	cify)	
ding Pł	n. After th funeral		27. Manner of Death  1   Natural 5 □ Pendi		iry y, Yea <i>r</i> )	28b. Time injur	y wo		28d. Describe	how injur	ry occurred		
Attend	ector: ector: by the	Certificate:	2 Accident Investi 3 Suicide 6 Could 4 Homicide detern	not be 28e. Place of Inj			street, factory, office				nd Number or Ru	ıral Route N	umber,
ital or	urs and ral Dir lled in			building, et					City or To				
e Hosp	within 24 nours after death.  To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	29a. Certifier 1 A Certifying (Check 2 Medical I only one) 3 Certifying	Physician: To the best of Examiner: On the basis of each Nurse Practioner. To the	my knowle examination best of my	edge, dea and/or inv knowledg	th occured at the tim vestigation, in my opir ae, death occurred at t	ne, date and place, a nion, death occurred a the time, date and pla	nd due to the c at the time, date ice, and due to t	ause(s) ar and place he cause(	nd manner as st e, and due to the s) and manner as	ated. cause(s) and s stated.	manner stated.
To th	Somp		29b. Signature and title of certifie				29c. Licen			29d. Da	ate signed (Mont	h, Day, Year,	
			30. Name and address of person	who completed sauce of	leath (Itan	23a\ /Tire				001	J, 2	J I Z	
		3	SOMI RIKHYE	who completed cause of C	3	11 N	J. 4th S	t., Oakl	and, M	1D 2	1550		
J	Stat Registra	.e	31. Date filed (Month, Day, Year) 0CT - 9	2012 %. Registr	ar's Signat	ure _	all						
	- Inogiotic			- Porton	- /-	7							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Registra 1. Decedent's Name (F inst Middle Last 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 3601 Hereford Valley Trail Ellicott City Howard 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 308-44-1383 **Director** 1 □ M 2 🔀 F Indiana 69 Jan 15, 1943 I Hygiena. other than "natural", or items 23a or 28a-f show vent, the Medical Evaminar must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director MD Howard Ellicott City 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3601 Hereford Vallev Trail 21042 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married φ 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √2 No Specify: 3 Divorced 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Own Home a 1 and 2 should be filad wit of Haalth and Mantal Hygle If Item 27 is marked othar ir other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Shannon Chambers Elizabeth Adelphia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3601 Hereford Valley Trail Ellicott City, MD 21042 Anthony J. Euler/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Paga 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 M Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/13/2012 | Anderson, Indiana nderson Mem. Pk. Ceme 21. Signature of Funeral Service Linensee 22. Name and Address of FacilitHarry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final OVARI Onset and Death Enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) Examil physician and s the burlal-transit or Attending Physician: The law requires that the death carlificate ba exacuted resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 88 signad by the attending I be detached for usa as IF FEMALE: es, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Other (specify) Pregnant at time of death Month 1 Yes 2 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown 1 🗌 Yes Completed this cartificate has bean s ral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 ☐ Yes 2 1 ☐ Yes 2 ☐ No : After this cartifice e funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manney of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes within 24 hours after daath.

To the Funeral Director: Af
completely filled in by the fu death. 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and add npleted cause of death (Item 23a) (Type

State Registrar 31. Date filed (Month, Day, Year)

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2012 рм 4:11 Margaret Felicebus Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia Gilchrist Hospice Care 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Days Hours Director 213-20-6085 88 07/16/1924 MD Usual Residence of Dece item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be incitified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director filed within 72 hours after death with the Maryland Ellicott City MD 1 Yes 2 No Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21043 4641 Roundhill Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ŽNo Specify: Yes, Give White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked oth, any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Rosina Stabile Claudino Comegna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4641 Roundhill Road Ellicott City, MD 21043 Claudia R. Halko - Daughter 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State dremation Center of MD: 10/08/2012 4 Dronation 5 Other (Specify) Hanover, MD Signature of Funeral Service License 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MENCLUS ease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) use as the burial-transit Hospital or Attending Physician: The lew requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death page 2 should be detached 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 2 3 Probably 4 Unknown 1 🗌 Yes been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician, within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 2 ဍ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27.\_Magner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural . 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 🔲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

**OCT 09** 

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2012 ea Michael Sept. 28 11:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3310 N. Leisure World Blvd., Silver Spring #212 Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 436-09-4223 Director 1 X M 2 D F 94 May 7, 1918 Texas Usual Residence of Decedent 28a-f shov 10b. County ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 3310 N. Leisure World Blvd., #212 20906 USA death v 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or Nollf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 1 Yes 2 No Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after Specify Asian 1 Yes 2 No Specify If Yes, Give Year or Dates.WWII 3 Nidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) 6 Tech Writer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Salvador James Fung permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Felix Gonzalez/Executor 58 Stratford Road, Southampton, NJ 08088 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20c. Location - City or Town, State Date Oct 2012 1 Burial 2 1 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd. W. Silver Spring. MD 20901 Part 1. Later the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Myeloid Leukemia

Due to (or as a consequence of): disease or condition mos Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) e bural-transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burfal-transit Cause Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 TResidence 6 Other (Specify) 1 Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 5 Pending 1 X Natural injury 1 ☐ Yes 2 ☐ No 2 ... Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2nd Date signed (Month, Day, Y 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 10+ Sept. 29, 2012 D60335 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) 0CT 03 2012

Paul Bannen, MD

18111 Prince Philip Drive, Olney, MD 20832

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2, 2012 5:58 P M FITZWATER ALLEN Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Shady Grove Adventist Hospital Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign Days Hours 219-48-4656 **Director** 1 X M 2 D F 63 Maryland June 29,1949 2 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Gaithersburg 1 Yes 2 X No October 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 20877 United States 9200 Edgewood Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed Specify: White 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Trucking Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Mary Eileen Moses Page 1 end 2 should be Ervin Brexton Fitzwater 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 end 2 shu Department of Health ar Importent: If item 27 is eny injury or other trau once. 9200 Edgewood Dr. Gaithersburg, MD 20877 Janet Fitzwater (Spouse) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Mountain View of the file ed Methodist 1 X Burial 2 Cremation 3 X Removal from State Abingdon, VA 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home (M01116)10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ myocardial disease or condition resulting in death) Medical Due to (or as a consequence of); Examiner connestive heart EAV5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit rate has been signed by the attending physician and page 2 should be detached for use as the burla-transit Exam coronary Cars that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 1 Yes 2 No Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a Was an death?
1 Yes 2 No performed' Yes 2 No 8 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🖾 Yes 2 🗌 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural
2 Accident 5 Pending injury Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Question of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) amarle H51791 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, Mambal 20850 center Drive, 9901 Kile, Do Medical amara 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 04 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 33859 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Fenwick Emma Margaret 2012 6:20 DM October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Bethesda Suburban Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) Days Hours Min (Month, Day, Year) 577-03-8496 Director 1 🗆 M 2 🖾 F 99 Yrs Nov. 23, 1912 Maryland Usual Residence of Deceden item 27 is marked other then "naturel", or items 23e or 28e-f show other treumatic event, the Medical Example must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 20902 3113 Medway Street USA 10/11/2 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 Specify White If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. 3 → Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Fenwick, Margaret Elementary/Secondary (0-12) College (1-4 or 5+) 12 Deputy Claims Examiner DC Government permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked othinany inlury or other treumatic event, once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Conrad Faunce Ada Goddard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Garfield Court, Gaithersburg, MD 20882 Dolores Bartlett/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. 6. 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY Suitland, MD 2012 Signature of Funeral Service Licensee

22. Name and Address of Facility
Francis J. Collins F
500 University Blvd.

3a. Part 1. Service the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring,MD 20901 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Subdural Hematoma disease or condition mo omb Medical resulting in death) Due to (or as a consumence of) Examiner 2 days Fa11 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consumence of). Per To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial trapes. use es the buriality Due to (or as a consequence of) resulting in death) Last 3 12 0 Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day 5 Other (specify) g Unknown 9 Unknown 11101 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy Fennick, Margaret 1 Yes 2 No Yes 2 N N 25. Was case referred to medical 8 **Division of Vital** 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 XYes 2 No မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 ☐ Natural 2 점 Accident 5 Pending injury fell down stairs 1 ☐ Yes 2 🖾 No Investigation 2:00 am 9/28/12 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Route Number, City or Town, State) 3113 Medway St., determined Silver Spring, MD 20902 Medical ( 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 1013112 066414 · Mi> rechnel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5602-B Shields Drive, Bethesda, MD 20817 Adam Schechner, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature 0 4 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 28, 2012 Edward Gresham L. 2:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Montgomery 3330 N. Leisure World Blvd. #105 Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 561-54-4316 1 🖾 M 2 🗆 F 100 24, 1912 Jan. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at. 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3330 N. Leisure World Blvd. 20906 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces 1 Never Married 2 Married Black, White, etc. 3 1 X Yes 2 □ No If Yes, Give 1 O Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 Nidowed 4 Divorced Specify: Black Year or Dates. 1932-57 Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 1 end 2 should be filed within 72 hof Health and Mental Hygiene. Item 27 is marked other than "nother treumetic event, the Med. st grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Executive Director Non-Profit Organization Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Gresham Ardella Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cassie Ramage Watson/Niece 812 Monument Avenue, Woodbridge, VA 22191 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of I Important: If it any Injury or of Once. 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State v. 2, 2012 Nov. Arlington National 4 ☐ Donation 5 ☐ Other (Specify) Arlington, VA 21. Signature of Funeral Service License Francis Coilins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and I for use as the burlattransit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-bransit Cause (Disease or Injur that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform Yes 2 No 1 ☐ Yes 2 ☐ No æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 □ No မူ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifie 1 Q Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Check 3 Certifying Nurse Practitioner: Jorthe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certif 29c. License number 8 MD OME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R SHER mo OME 31. Date filed (Month, Day, Year) State OCT 03 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. edent's Name (First, Middle | Last 3. Time of Death 2. Date of Death Physician/ Month Medical not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** frince George hover ear If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthda **Funeral** Months Min (Month, Day, Year) Hours 92 Yrs 1 **X**M 2 □ F Director 10-08-1919 Wash., D.C. or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD 1 XYes 2 No Prince Georges Mitchellville 10e Street and Number ò 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be r Funeral 10450 Lottsford Road 20721 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ian "natural", or ite Medical Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: **Black** Specify. Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 i. Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "no any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Chauffeur Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Turner Gibson Laura Tatum 19a. Informant's Name/Relationship (Type, Print) boosing Address Street and Number or Rural Route Number, City or Town, State, Zip Code)
AVENUE Hamilton, New Jersey Osei Omowale (Son) 08610 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Nat. Cem: 10-06-2012 Laurel, MD Ralph Williams, II Funeral Service, 5202 PrincetonsDelightDr., Bowie, MD 20720 23a. Part 1. Enter the disease, or complications that caused the death ode of dying, such is ardiac or respiratory arrest. shock, or heart failure. List only one com-Interval Between Onset and Death e ch line. Immediate Cause (Final Ph si ian/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death signed by the a 2 🗆 No 9 Unknown 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔭 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autonsy page perforn 2 No Yes 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 X No 1 Tes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 1 Natural Accident Investigation D rector filled i by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical within 24 hound To the Funer completely file 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year)

45M

State

of death (Item

32. Registrar's Signature

of person who completed

Mas

		A	Please mend 25,27,28a-f,	Type or Pringer me 893	t in E	lack in	ndelible Inl	k <b>. Ensur</b> Jealth an	<b>re All Copie</b> ad Mental Hy	s Are Le	gible.			
			State Registrar				tificate of L			Reg. No. 2	0/2	33862		
Н	Physicia Medic		1. Decedent's Name (First, Middle, La.  WAYNE	,	JDS	SON			2. Date of De Month	Pay Pay	Year	3. Time of Death		
	Examin		4a. Facility Name (if not institution, give	e street and number)	e street and number)  4b. City, Town, or Location of D  REPARILITATION GUTEN.  CY						nty of Death	RUNDEL		
	Funeral Director		5. Social Security Number 6. S	7. Age	(In yrs. las	at birthday)  Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bir Min. (Month, Da Jan.19	th ay, Year)	9. Birti Cou	9. Birthplace (State or Foreign Country) Hornell, NY		
	and show	ior	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation		17	,1740	1101	10d. Inside City Limits		
	e Maryl r 28a-f notified	Director	MD Prince 0	George's			Bowie			40. 00		1 X Yes 2 □ No		
	is 23a o	Funeral	12129 Long Ridge	Lane				20715		10g. Citizen	USA	untry?		
9800	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Fur	11. Marital Status  1  Never Married 2 🕅 Married 3  Widowed 4  Divorced	12. Was Decedent Ev Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates.	10		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 🏋 No		? (Specify Yes or No- uerto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White			
215-(	ר 72 אסר 72 אסר an "nate Medica	mple	15. Decedent's Elementary/Secondary (0-12)	ade completed)		(Give	lent's Usual Occup kind of work done o O NOT use retired)	ation during most of	working	16b. Kind o	Business/I	Industry		
121	filed within al Hygiene d other th	Be Co	17. Father's Name (First, Middle, Last)	College (1-4 or 5- 4		tant Name (First, Middle,			keyC1ub					
ylan	should be file and Mental I 7 is marked o raumatic eve	To	Robert Hudson	urie)										
, Mar	nd 2 shou ealth and n 27 is m er traum		19a. Informant's Name/Relationship (1 Judith A. Hudson,		ural Route Number, City or Town, State, Zip Code) Bowie, MD 20715									
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other:		20a. Method of Disposition  1 □ Burial 2 X Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Metro Crematory  20c. Location - City or Town, State 10/02/2012  Baltimore, MD											
Ball	permit Depart Impor any in		21. Signature Fun ral Service Lieen	me 715										
Н			Approximate Interval Between Onset and Death											
Jan.	Ph_sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a			DEI	MENT	7/12			Oriset and Death		
	Examiner	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	conseque	ence of):				1-1				
	e executed cian and ourial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to for as a	c									
09,	ate be ex ohysician the buria		Tooding in addity 225.	■ d				HAPPROVED BY MEDIC	hre .					
. Box 68760	the Hospital or Attending Physician: The law requires that the death certificate be fin 24 hours after death.  the 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physici the Funeral Director: After this certificate has been signed by the after the physicial director, page 2 should be detached for use as the but pietely filled in by the funeral director, page 2 should be detached for use as the but after the funeral director.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of Live Birth 2 Pregnant at 9 Unknown	Fetal	death 3 L	Ectopic pregnanc Other (specify)	CERTIFICATIV	(1)		Date of deli Month	ivery Day Year		
, P.O	es that t signed b		Part II. Other significant conditions of	contributing to death bu	t not resu	•	inderlying cause given ACTURE	ven in Part I.				the cause of death?		
ords	iw requii is been 2 should	Completed by	Depnesion		-				24a. Was	an 24	b. Were aut	copsy findings available completion of cause of		
l Rec	n: The la ficate ha or, page	Com	25. Was case referred to medical	HY GROW	1A		00.5	(D. II	perf 1 🗆 Yes	ormed? 24 No	death?	2 🗆 No		
Vita	hysicia his certi al directo	To Be	examiner?				nt 3 🗆 DOA Othe	er: 4 X Nursi	(Check only one)	idence 6 $\square$ C	ther (Speci	fy)		
ou of	nding Path. r: After t	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigatio	28a. Date of injun (Month, Day, n JUNE 11,	Year)	28b. Time of injury 2. IINK	work	yat ⊲? Yes 2.X∏ No	28d. Describe  SUBJECT		urred			
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law within 24 burus after death.  To the Funeral Director: After this certificate has i completely filled in by the funeral director, page 2.	l Certif	3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined	De Place of Injur	y - At hon		eet, factory, office		28f. Location ( City or To	Street and Nur wn, State) 12 OWIE, 1	nberor Rur 129 Lo 1D	ONG RIDGE		
	ne Hospi n 24 hou ne Funer pletely fill	Medical	(Check 2 Medical Exam	vsician: To the best of r niner: On the basis of ex se Practitioner: To the	amination	and/or inves	tigation, in my opinio	on, death occu	rred at the time, date	and place, and	due to the o	ause(s) and manner stated.		
	To the virthing control of the contr		29b. Signature and title of vertifier	my ( w	M	MD	29c. License	e number 0627	395	29d. Date sig	ned (Month			
1	44		30. Name and address of person who ALROWO A GO MAD	200: Ada	ath (Item :			B 6	LEN BUT	LIVIE	MD	21061		
	Sta Registr	te	31. Date filed (Month, Day, Year) OCT 05 2	012 32. registra	's Signatu		all		10.0					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State 33863 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 2:35 AM MILDRED OCT HOLLAND 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HEBREW HOME ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday **Funeral** Director 578-38-6427 1 M 2 XF 83 Yrs OCT. 14, 1928 WASH. DC er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 X Yes 2 No MD MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6121 MONTROSE ROAD 20852 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian med Forces?
X Yes 2 \( \square\) No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 1 ☐ Yes 2 🔀 No Specify: Specify: BLACK 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Je filed with. The Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene, Important: If item 271s marked other than any Injury or other traumatin means in the page. College (1-4 or 5+) GOVERNMENT MANAGEMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ HARRY C. ANNIE CONSTANCE SCOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VALERIE MITCHELL/FRIEND 3805 SUN FLOWER CIRCLE MITCHELLVILLE, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) RIVERDALE, CREMATORY 10-5-2012 RIVERDALE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failule. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death Physician/ Chronic disease or condition resulting in death) Renal Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): inding physician a use as the burial-Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ for in the past 12 months? Month Day Year 1 Yes 2 the Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 s has perform 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2X No Other: ဂ 1 Inpatient 2 ER/Outpatient 3 DOA Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred eral Director: After filled in by the funer 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier MD 069568

3 JM

Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Registrar DHMH 17 Rev 06-2011 6121 Montrose Rd

32. Registrar's Signature

Rockville, MD 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A chilakamars, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 33864 Reg. No. 20 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:30 A M Physician/ 06tober Pay 2012ar Annette HARRISON Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Montgomery **Examiner** 4b. City, Town, or Location of Death Silver Spring 222 Crestmoor Circle Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 124-18-5590 Days Hours New York **Director** 1 M 2 XF 88 July 4, 1924 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Silver Spring Montgomery Maryland 1 Yes 2X No ms 23a or 2 must be no 10e. Street and Number 10a. Citizen of What Country? Funeral United States 20901 222 Crestmoor Circle "natural", or items dical Examiner mu death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married and 2 should be filed within 72 hours after Health and Mental Hygiene. tem 27 is marked other than "natural", or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 ₩ Widowed 4 Divorced Specify: white Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Education 4 Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Becky Cohen Louis Lazarus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State Zip Casting 222 Crestmoor Circle, Silver Spring, MD 20901 f Health a Lesley Choy, Daughter 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. Lebanon Cemetery 10/03/12 Adelphi, MD 21. Sign Lionsee Forehainsky Hebrew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ seizure disorder disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Normopressure Hydrocephalus Sequentially list conditions Due to (or as a consequence on) cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be P.O. Box 68760 as the IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Dementia 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Pulmonary Emboli 24a. Was an autopsy performed? 1 Yes 2 X No certificate the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5\(\bigg\) Residence 6 \(\sum \) Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? \_1 □ Yes \_2 □ No 28d. Describe how injury occurred 1 XNatural 5 Pending within 24 hours after death.

To the Funeral Director: A:
Completely filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical 29a. Certifier (x) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, f the basis of examination and/or investigation, in my opinion, in my opinion, in my opinion of the basis of examination and/or investigation, in my opinion, in my opinion of the basis of examination and/or investigation, in my opinion, in my opinion and on the basis of examination and/or investigation, in my opinion, in my opinion of the basis of examination and/or investigation, in my opinion, in my opinion and on the basis of examination and/or investigation, in my opinion, in my opinion and on the basis of examination and/or investigation, in my opinion of the basis of examination and/or investigation, in my opinion of the basis of examination and/or investigation, in my opinion of the basis of examination and/or investigation, in my opinion of the basis of examination and/or investigation, in my opinion of the basis of examination and/or investigation, in my opinion of the basis of examination and/or investigation of the basis of examination and/or investigation.

Registrar

DHMH 17 Rev 06-2011

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

0.3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

re#103

29c. License number

Dashma

50639

an

0232

29d. Date signed (Month, Day, Year)

Amend #26 per PHY AACO Health Dept	10 / 12 1/11	ype or Print in E				•		gible.			
And realth tope	For State	State of Maryland		nent of F cate of L		Mental Hy	0.0	110	22065		
	Registrar  1. Decedent's Name (First, Middle, Last)		Ceruno	ale of L	Jean	2. Date of De	Reg. No.		3. Time of Death		
Physician/ Medical	Stephen Isaacs					Septer	nber 29	9 1201	2 11:40 <sup>a</sup>		
Examiner	4a. Facility Name (if not institution, give str 11402 Walpole Ct		4b.	City, Town, or Bowie	Location of Death	h 4c. County of Death Prince George's					
Funeral	Social Security Number     6. Sex	7. Age (In yrs. la		Inder 1 Year		8. Date of Bir (Month, Da	place (State or Foreign try)				
Director ≥	Usual Residence of Decedent	M 2 □ F 85	Yrs.			Dec. 2	7 1926		yland —————		
Baltimore, Maryland 21215-0036  permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Importent: if item 27 is marked other than "netural", or items 23e or 28e-f show any injury or other traumetic event, the Modic Eventral must be notified at once.  To Be Completed by Funeral Director	10a. State 10b. County		, Town or Location					1	0d. Inside City Limits  1X□X√es 2 □ No		
leath with the Maryland tems 23e or 28e-f sho er myst be notified at Funeral Director	Maryland Prince 10e. Street and Number	George is E		f. Zip Code	10g. Citizen o	f What Cour	ntry?				
h with	11402 Walpole Ct			2072				USA			
ter deat to riten to riten	11. Marital Status  1 Never Married 2 Married	Was Decedent Ever in U.S Armed Forces?     We Yes 2 □ No	i. 13. Was D If Yes,	ecedent of H specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - Americ ack, White,	etc.		
Maryland 21215-0036 2 should be filed within 72 hours after the end Mental Hygiene. 27 is marked other than "netural", or traumetic event, the Modical Event To Be Completed by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates. 1945 -	Specia	fy: B1	ack						
21215-003 irithin 72 hours at lene. r than "netural" the Modic I Ex	15. Decedent's Educ (Specify only highest grade	completed)		Usual Occup f work done of T use retired)	during most of work	ing	16b. Kind of	Business/In	dustry		
212 d within ygiene, her the rt, the l	Elementary/Secondary (0-12) 8th	College (1-4 or 5+)	Taxi	Cab I	river		Se1f	Emp1	oyed		
and be flied wrtai Hy ced oth c event	17. Father's Name (First, Middle, Last)	2.00			18. Mother's Nam	e (First, Middle) Queen		ne)			
ryla ould be d Men marke metic	Stephen G. Isa		40b 84-10 Ad	denna (Chronit				State Zin (	Cadal		
Ma d 2 shc arth en or traus	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carla Isaacs (Grandaughter) 11402 Walpole Ct. Bowie, Md. 20720										
or Her of Her r other	20a. Method of Disposition  1 XBurial 2 Cremation 3 R	20b. P	lace of Disposition emetery, crematory	(Name of or other place	(e)	Date	20c. Location	•			
Baltimore, semit. Page 1 enc Department of Hee mportent: if item my injury or othe page.	4 Donation 5 Other (Specify)				ark 10/	5/12	Annapo	olis,	Ma.		
Ball permi Depar Impo any ir	21. Signature of Funeral Service Licensee		Wm .	Reese	ss of Facility & Sons est Dr.	Mortu	ary, F	A.	1401		
	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the death						70 . T	Approximate Interval Between		
~ Physician/	Immediate Cause (Final disease or condition	Cerebrou	rascular	Acci	dent				Onset and Death		
Medical Examiner	resulting in death)	Due to (or as a consequ	ierice of):	c CA	DIOVASO	ILAR	DENTA	-65			
<u>e</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of the Constant Description Descriptio	ience of):	<u> </u>	3.001,00		٠٠٠٠٠٠	-			
executed an and rial-transit	that initiated events	Insiden D  Due to (or as a consequ	CHENDE	NT O	MBETES	Meur	rus				
o a = _											
Box 68760 death certificate b the attending physical for use as the the desiral for use the the desiral for use the the desiral for use the the for use the the for use the formula for use the fo	d d			- III. <del>2</del> 40							
th certi trendin or use	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Bc. If yes, outcome of pregna 1 Live Birth 2 Feta	al death 3 🔲 Ect		су			Date of deliv	ery Day Year		
ords, P.O. Box 68760 requires thet the death certificate be been signed by the attending physicis should be detached for use es the buildeted by Physician/Medica	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4  Pregnant at time of c	death 5 □ Oth	er (specify) _							
P.O. s thet the gned by to detact			A				. /		he cause of death?		
rds, equires hould it hould it	Hyperfersion,		CEMIT,	16211	THEIDAC				bably 4 Unknown		
₩ 3 Ø O I D	VASCULAR DIFE	ASE	<u> </u>			24a. Was auto perf	opsy formed/ 2 X No	prior to co death? 1 \sum Yes	mpletion of cause of		
tal R clan: The	25. Was case referred to medical			26. P	lace of Death (Chec		2 (A NO)	- I des	2 🗆 🙀		
hysic this ce al dire	1 Yes 2 No	ospital: 1  Inpatient 2  I 28a. Date of injury	ER/Outpatient 3 28b. Time of		-4-1) Nursing H	1	idence 6 0		)		
in of ading Figure 1: After e funer cate	Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	28c. Injur wor 1 1		28d. Describe	how injury occu	irred			
Division of Vital Records, P.O. Box 68760  To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours effer death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu Medical Certificate: To Be Completed by Physician/Medical	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		actory, office			(Street and Nurr wn, State)	nber or Rura	l Route Number,		
he Hospitel in 24 hours he Funerel pletely filled	(Check 2 Medical Examine	cian: To the best of my know er: On the basis of examination	n and/or investigation	on, in my opini	ion, death occurred a	at the time, date	and place, and	due to the ca	use(s) and manner stated.		
o the vithin 2 to the compile	only one) 3 L Certifying Nurse  29b. Signature and the of certifier	Practitioner: To the best of r									
<b>♠</b> .₺	> Cler	n)		23	31997		10/0	2/20	12		
一多年	30. Name and address of person who could new ConDo	mpleted cause of death (Item	1 23a) (Type, Print) 3 MED C	ACPO	noy Sts	100	ANNS	D M	Day, Year)  12  21401		
State Registrar	31. Date filed (Month, Day, Year)  OCT 0 4 20	1 32. Retristrar's Signa	ture de la seconomica del seconomica de la seconomica del seconomica de la seconomica de la	w	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Kraus Helen S. 12:45 AM September 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Crofton Crofton Care & Rehabilitation Center Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 89 **Director** 216-18-9247 1 M 2 DXF March 04,1923 Virginia 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Anne Arundel Crofton 1 ☐ Yes 2 XNo 5 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21114 USA 2131 Davidsonville Road "natural", or items death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after White 1 ☐ Yes 2 X No Specify. Specify Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Administrative Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Frank Shemenski Frances Kwasny and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7700 Keyport Terrace Derwood, MD 20855 Frank Shemenski / Nephew permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 10, 1 X Burial 2 Cremation 3 Removal from State October Crownsville, MD 4 Donation 5 Other (Specify) MD Veterans Cemetery 2012 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 495 Ritchie Hwy, 23a. Part 1. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Condio Vancular Distal Phylician enotic Medical Examiner movercular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami -transit Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to ( as a nsequence of): burial-t attending physician Physician/Medical Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month for Month Day Year Pregnant at time of death ed by the a detached f 1 Yes 2 Unknown P.O. signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performe death? After this certificate director, 25. Was case referred to medica Be 26. Place of Death (Check only one, Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA ᅆ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident n 24 hours after death.
he Funeral Director: Afte 5 Pending work 1 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou To the Fune completely fi 29a, Certifier (Check 3  $\square$  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signature 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

20108

14300 GALLANTRY LN#222 BOWIE MD28719

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33867 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Kazanjian Berjouhi 9:15 A M 09 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care Potomac Potomac Montgomery Social Security Number 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 😿 F 89 578-58-0155 Director 05/20/1923 Turkey Usual Residence of Decedent 2 should be filed within 72 hours and, the and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show are event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director DC Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5315 Connecticut Avenue NW, Apt. 208 20015 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 W No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 2 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: White Completed 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Elizabeth Arden life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Beauty Products Manicurist other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Kazanjian <u>Arshag Kazanjian</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 10814 Hillbrooke Lane Potomac, MD 20854 Ani Kazanjian / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/03/2012 | Falls Church, Virginia <u>Nation</u>al Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons LLC. CC0379 5130 Wisconsin Avenue NW Washington, DC 20016 23a. Part 1. Enter the disease, or confolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between advanced Dementia. Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** thrive Foilure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burjal-tgangit Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy

Shoppent at time of death 5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months Month Day Year 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Hiknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? 2 100 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural Pending Division 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year) 00057458.

Registrar

of Vital

DHMH 17 Rev 7/2009

Pinky Singh, M.D. 8218 Wisconsin Avenue Suite 305 Bethesda, MD 20814

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

OCT 03 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistrarAmend #18 Per FH JM 10/90/ett@ficate of Death 1. Decedent's Narrie (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joan B. Lewis Month 9 2012 28<sup>Day</sup> 6:35 PM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Clinton **Examiner** Southern Maryland Hospital G 5. Social Security Number 100-28-5058 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) 6-16-1935 77 Director 1 □ M 2 🗓 F NY Show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Р MD G District Heights 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1763 Addison Rd. South Funeral 20747 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Black, White, etc. <u>۾</u> Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 M Widowed 4 ☐ Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) 5 + Elementary/Secondary (0-12) Dietitian Private it. Page 1 and 2 should be filed with them of Health and Mental Hygien trant: If item 27 is marked other 1 njury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Mable Haynes Mabel Hayes Clyde Benton 9a. Informant's Name/Relationship (Type, Print) William H. Lewis TV 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2805 W. Mulberry St. Baltimore MD. 2 (Son) Baltimore, 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20b. Place of Disposition (Name of Cem cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Suitland MD. 10-5-12 Lincoln Mem"1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hunt Funeral Home 908 Kennedy St. N.W. Wash, D.C. Signature of Funeral Service Licenses CC353 Hunt Tranco 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician ٤ SRSBROVASCULAR disease or condition resulting in death) Medical Jue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy 1 ☐ Yes 2 No 1 Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မူ 1 Dinpatient 2 ER/Outpatient 3 DOA 27 Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending (Month, Day, Year) death. 2 Accident after death Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Place of Injury - At horne, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the trest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

To the F only one 29b. Signa**(**û 29d, Date signed (Month, Day, Year) 20/2 11/24 th (Item 23a) (Type, Print) ame and address of per 75Q3 0 URKATTS State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 3.45 PM SEPTEMBER Donald Edwin Miller 27 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Arunde1 Anne If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) Days Hours Min (Month, Day, Year) Director 215-30-4165 15254M 2 □ F 80 8/17/1932 MD 28a-f ahow 10b. County 10a, State 10c. City. Town or Location 10d Inside City Limits the Madical Examiner must be notified at Director Anne Arundel 1 Yes 2 No Glen Burnie 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? items 23a Funeral 7975 S. Crain Hwy. #320 21061 USA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1XXYes 2 \( \text{No WWII} \) Black White etc. "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2XXX No Specify White 3 ₩Widowed 4 □ Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mantal Hydrac III Indicate II Itan 27 ia marked other than 'any injury or other traumatic event, it is Ma Elementary/Secondary (0-12) College (1-4 or 5+) 12 Installation Tech Phone Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည should ba Guy Emory Miller Florance Rosetta Humphrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) parmit. Paga 1 and 2: Dapartment of Health Melissa Quirk daughter Severn Tree Blvd. Severn. MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem 10/2/2012 | Crownsville, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. Signature of Funeral Service Licenses Jak Ridgely Ave. Annapolis, Md 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENCEPHALITIS WES Physician/ N disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami b Hospital or Attending Physician: T elaw raquires that tha daath cartificata ba axacutad 24 hours after death.
1 hours after death.
2 hours after death.
3 Funeral Director: Aftar this certificate has baan signed by tha attanding physician and lataly fillad in by tha funaral director, page 2 s \times \tim that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day 5 Other (specify) Pregnant at time of death a llnknown P.0. Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 🗵 No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy Yes 2 TXN 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕅 No DONAL မြ 1 Nanpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🛱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. complataly 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To tha only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D0061219 Singh SEPTEMBER 27, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BWMC HOSPITAL 301 HOSP DR GLENBURNIE MD 21061 TARVINDER ARORA 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

		-	For State Registrar			d / Depa		Health and	Mental Hy		7   2	22270		
		٥	Decedent's Name (First, Middle, Las	t)					2. Date of De	ath	1-6	3. Time of Death		
	Physicia Medic		Mary R. McGar	vey		Month Octobe	er 5 2	Year 2012	12:45 p M					
	Examin		4a. Facility Name (if not institution, give	street and number)				or Location of De	ath		ty of Death	L		
Seman	-		Charlestown Reti 5. Social Security Number 6. So		- (l- , , , ,  -	-6	Cator	nsville ar   If Under 24 H	- Lo - : : : : : : : : : : : : : : : : : :	Baltimore				
	Funeral Director		219–18–3700 1 security Number 1	M 2 🔼 7. A9	93	st birthday) Yrs.	Months Day			th 1'9''9	9. Birth	place (State or Foreign htry) MD		
			Usual Residence of Decedent						100/02/					
	yland -f shc ed at	ctor	10a. State 10b. County		1	, Town or Lo					1	10d. Inside City Limits		
	r 28a notifi	Director	MD Howard  10e. Street and Number			Ellico	10f. Zip Code					1 Yes 2 XNo		
	vith th	eral	9325 Dunloggin F	heo!			210		ļ	10g. Citizen of	ted St			
	eath v	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S.	. 13. V			Specify Yes or No- erto Rican, etc.)		ace - Americ			
98	fter de		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 If Yes, Give	No	- 1	f Yes, specify Cu		rto Rican, etc.)	-	ack, White,			
21215-0036	ours a tural	Completed by	3 Widowed 4 M Divorced	Year or Dates.						Specif	AAT	nite		
15	72 hc n "na Aedic	nple	15. Decedent's E (Specify only highest gra	de completed)		(Give I	lent's Usual Occ kind of work don O NOT use retire	e during most of w	orking	16b. Kind of I	Business Inc	dustry		
212	within giene. er tha		Elementary/Seconday (0-12)	College (1-4 or 5				" !echnicia	n	Bendix	Corpo	oration		
pu	filed all Hyg		17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Middle,					
yla	Ment Marke natic	မ	Julius Ratas			·		Agath	a Gonglie	ewski				
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilt and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "matural", or items 23a or 28a-f show amportant: If item 27 is marked one of the item 27 is marked of the item 27 is marked of the item 27 is marked one of the item 27 is marked of the item 27 is marked of the item 27 is marked one of the item 28a or 28		19a. Informant's Name/Relationship (Ty	, , ,		1	-		Rural Route Numbe			,		
ē,	F Heal		20a. Method of Disposition	-1	20b. Pla	ace of Dispo	sition (Name of	rin Road	Ellicott	20c. Location				
Baltimore,	Page lent or nt: If in ry or		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Denation 5 ☐ Other (Specif			-	atory or other p		10/2012	Thurm	•			
alti	permit. F Departm Importa any inju once.		21. Signature of Funeral Service Licens	1	1110.							lly FH Inc.		
_	9 9 <b>E 6</b> 9		- Charle	mell	)	41	12 Old	Columbia	Pike Ell	licott (	City,	MD 21043		
	Physician/		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line	9.			ying, such as cardi	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death		
	Medical		disease or condition resulting in death)	a. VelStu			nha				-			
	Examiner		Sequentially list conditions.	h ———										
	d d	Examiner	if any, leading to immediate	Due to (or as	a conseque	ence of):								
	be executed sician and burial-transi	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):								
0	e be executed ysician and le burial-transit	ical		,		•								
9289	eath certificate b attending physi I for use as the b	Aedi	_	u										
99 ×	endin r use	an/N	Zob. Was decedent pregnant	23c. If yes, outcome 1 Live Birth			Ectopic pregna	ıncv		23d. D	ate of delive	ery		
Вох	deatl	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant a			Other (specify)	,		M	lonth	Day Year		
P.O.	es that the des signed by the s I be detached I		Part II. Other significant conditions co	ntributing to death b	ut not resu	Ilting in the u	nderlying cause	given in Part I.	23e. Did to	obacco use con	ntribute to th	e cause of death?		
S, F	ires the signer of the contract of the contrac	Completed by										pably 4 🗹 Unknown		
ord	v require s been si should I	olete							24a. Was	an 24b.	. Were autor	osy findings available		
3ec	The law cate has page 2 s	lmo:							autor perfo	rmed?	prior to cor death? 1 \square Yes	mpletion of cause of		
a	sician; The certificate I rector, page		25. Was case referred to medical examiner?				26.	Place of Death (Cf		2 (5 110)	1 1 103	2 140		
Ξ	Physic this ce al dire	욘	1 Yes 2 Yo			R/Outpatien	1 3 □ D0A		Home 5 Resid	ience 6 🗆 Oth	her (Specify,	)		
n o	ding F h. After i funera	ate	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of inju (Month, Day		28b. Time of injury	28c. Inj wo M 1	uryat ork? □Yes 2□No	28d. Describe h	ow injury occur	red			
Sio	Atten	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ıry - At hon	ne, farm, stre			28f. Location (S	Street and Numb	ber or Rural	Route Number.		
Division of Vital Records,	rs afte		4 - Homelde determined	building, etc	:. (Specify)				City or Tow					
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 brours after death.  within 24 brours after death.  completed filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Exami	ician: To the best of ner: On the basis of e	my knowle	edge, death o	ccured at the tin	ne, date and place	and due to the car	use(s) and manner	ner as state	d. use(s) and manner stated.		
	To the within 2 To the comple		only one) 3 Certifying Nurs 29b. Signature and title of certifier	e Practioner: To the	best of my	knowledge, d	eath occurred at	the time, date and passe number	lace, and due to the	e cause(s) and m	nanner as sta	ated.		
	F 8 F 0		Kusungur	hunget	one			65717		10/5/1		Jay, rear		
		1	30. Name and address of person who c	ompleted cause of d	eath (Item 2	23a) (Type, P	rint)	•				: /		
	10		Kristin T			/ 🗸 ! !	rlaide	n Chai	ce lan	e Cat	tonsv	ille 21228		
	Stat Registra	e	31. Date filed (Month, Day, Year) 9 2	32. Fegistra	ar's Signatu	A A	a Ked					9		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 <sup>Year</sup> 2012 Olive Blanche Martin  $A^{M}$ Medical 3:45 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dennett Road Manor Nursing Home Oakland Garrett 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthplac Country) MD Days Months Hours Min. (Month, Day, Year) 03/26/1923 Director 220-16-2546 1 □ M 2 M F 89 Yrs Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the M dical Examiner must be notified at permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Anthon". 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No MD Garrett Mt. Lake Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 702 Pocahantas Street 21550 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ş 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give 1 ☐ Yes 2 X No Specify: 3 ₩ Widowed 4 □ Divorced Completed Specify Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Homemaking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Blamble Esther Liller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Sines / Daughter 505 Pocahantas Street, Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🕱 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place. 4 ☐ Donation 5 ☐ Other (Specify) 10/11/2012 St. John's Lutheran Cemetery Oakland, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility Burdock-Fredlock Funeral Home, P.A. 21 North Second Street, Oakland, MD 21550 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ SCEROTIC CORME disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any Lading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a nonsequence or) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-tran that initiated events Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Day Year within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy om 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ဥ 1 🗌 Yes Other 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) . Manner of Death Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident 1 🗌 Yes 2 🗆 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) H26154 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

OCT 11

P. Daniel Miller 69 Wolf Acres Road Oakland, MD 21550

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33872 1 - State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Shemika Delaine Mosley Schoper Medical Facility Name (if not institution, give street and number, **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Med a lata 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 218-98-8811 Director 1 M 2 F 35 01-17-1977 Washington, DC Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits Examiner must be notified MD Charles Waldorf 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 33 Tadcaster Circle 20602 USA "natural", or items 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? þ Black, White, etc. 1 Never Married 2X Married If Yes, Give 1 ☐ Yes 2 X No Specify Specify: Black Completed 3 Widowed 4 Divorced Year or Dates the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha Private Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Phillip S. Mosley Essie Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory L. Bosman/Husband 33 Tadcaster Circle Waldorf, MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Riverdale Pk Crem. 10-9-12 Riverdale, MD injury, 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service Lin 22. Name and Address of Facility Ronald Taylor II FH MOILLY Kanal 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) trar that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician Physician/Medical that the death certificate be P.O. Box 68760 the as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for the past 12 months? Pregnant at time of death Month Day Year signed by the at d be detached for 1 Yes 2 Unknown 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s has autopsy performed Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate by 1 🗌 Yes funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other: မ 1 Yes 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 5 Pending iniury 2 🗌 No M Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 □ Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of of 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

25m

DHMH 17 Rev 06-2011

Ferraro

82. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene 2 () | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9-23-2012 Year JUDY MOFFETT  $P^{M}$ Medical 7:00 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7610 CARISSA LANE 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Davs 6-22-1953 Months Hours Director 224-86-9440 1 🗆 M 2 🗶 F 59 VA Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Maryland 10c. City, Town or Location Director 10d. Inside City Limits notified MD PG LAUREL Yes 2 No 0 10e. Street and Numbe 10f. Zip Code 20707 ms 23a or must be r 10g. Citizen of What Country? 7610 CARISSA with 1 Funeral LANE r death √ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Examiner ò ģ 1 Never Married 2 Married Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2X No Specify: Specify: BLACK "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the 12TH SUPERVISOR FBI/GOVERNMENT event, Be Department of Health and Mental Important if item 27 is marked off any injury or other traumatic and once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည GEORGE LITTLE ORA BUNCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LARRY E. MOFFETT/HUSBAND 7610 CARISSA LANE, LAUREL, MD 20707 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MARY 14 NOT PITES AND 10-4-2012 CEMETERY AT CHELTENHAM 1 X Burial 2 Cremation 3 Removal from State CHELTENHAM, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. of Funeral Service Lice 21. Signa Oles 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Par 1. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ METASTATIC PANCREATIC CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last STROKE Due to (or as a consequence of): Exami HYPERTENSION attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 X No
9 ☐ Unknown Pregnant at time of death Dav Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1  $\square$  Yes 2  $\overline{X}$  No 3  $\square$  Probably 4  $\square$  Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this ce flicate h completely filled in by the funeral director page. performed? Yes 24 No 1 ☐ Yes 2 X No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 5 Pending work 2 Accident
3 Suicide
4 Homicide Investigation 1 Tes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the build of my included death annursed at the time date and place and due to the cause(s) and manner at attact. (Check 29b. Signature and title of certifie 29c. License number D53209 9-28-12

10 JM

State Registrar

DHMH 17 Rev 06-2011

ORIGINAL

CLINTON, MD 20735

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURRATTS RD.

Registrar's Signaty

PIERSON 7503

42012

Date filed (Month, Day, Year)

ULIO

11011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ KAREN MINOR Month 9-28-2012 8:52 AM M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PG CLINTON SOUTHERN MARYLAND HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8 Date of Birth Birthplace (State or Foreign Country) Days (Month, Day, Year) 579-78-5363 Hours Min. Director 1 M 2 XF 54 2-25-1958 DC Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health end Mentai Hygiene. ms 23a or 28e-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No PG CHELTENHAM 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10504 GLOUCESTER LANE 20603 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 6 ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other then traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) FEDERAL GOVERNMENT PROCUREMENT ANALYST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ CLARZELL MINOR QUEEN ESTER CLARK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $2045\ ROSEWOOD\ DRIVE, WALDORF,\ MD\ 20601$ Department of Health e Importent: If item 27 is eny injury or other trai once. FRANK DIXON IV/SON 20a. Method of Disposition 20b. Place of Disposition (Name of RIVERDALE TO DISPUSSION FRANKE THE REMATERY 10-2-2012 RIVERDALE, MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility POPE FONERAL HOME, P. A. Signature of Funeral Service License 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 Part 1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physicien: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funerel Director, After this certificate has been si completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 12 Jin who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mary J. Mayo 20 cam Medical. Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Maryland Baptist Aged Home Baltimore Baltimore City Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours Director 153-16-3891 1 🗆 M 2 🔀 F 95 Yrs. Usual Residence of Decedent 08/31/1917 Virginia th and Mental Hygiene. 27 is marked other then "naturel", or Items 23e or 28e-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Md Baltimore City Baltimore 1 IX Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1506 Lakeside Ave. 21218 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married ģ 1 Yes If Yes, Give 2 X No Black White etc. 1 ☐ Yes 2 No Specify. Specify: African Completed 3 X Widowed 4 ☐ Divorced Year or Dates American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 License Practical Nurse Pri<u>vate</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Page 1 and 2 should be Johnson Ida Morrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Janice M. Mayo / Daughter 1506 Lakeside Ave. Baltimore, Md 20a. Method of Disposition permit. Page 1 a
Department of H
Importent: If ite
eny Injury or ot 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 10/8/12 Brentwood, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3401 Bladensburg Rd Brentwood, Md Silta Jance Fort Lincoln Funeral Home 20722 Part 1. Enter the dise shock, or heart failure se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, . List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): igned by the attending physicien and be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 23d. Date of delivery in the past 12 months? Pregnant at time of death ☐ Yes 2 No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown page 2 s 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an performed? Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 🗌 Yes 2√2 No 은 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 After this certificate funeral director, pag s after de... ol Director: Afte filled in by

Baltimore, Maryland 21215-0036

To the Hospital o within 24 hours at To the Funerel D Sal

Suicide

6 Could not be

determined

rne Funer	Medica	29a. Certifier (Check only one)  1	STION IN MY Opinion death occurred at the time. det	
000		29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
5m		30. Name and address of person who completed cause of death (Item 23a) (Type, Printing 1977)		7/201
Chal		31. Date filed (Month Day Year)	condition son silver	01001

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year Joe Nathan Moore Sr. 2018 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death
Cheverly Examiner 4c. County of Death Prince George Prince George' Hospital Center 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 422-60-8930 1**X** M 2□F 67 **Director** July 15,1945 Alabama Usual Residence of Dece 28a-f shov 10b. County 10a State City, Town or Location Landover 10d. Inside City Limits the Maryland Director Maryland Prince George's notified 1 Yes 2 No 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a with 6600 Hawthorne Street 20785 United States of America items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? Black, White, etc ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates. Specify: Black 3 X Widowed 4 □ Divorced "natural" Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government Special Police 10 permit. Page 1 and 2 should be filed in Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ McKinley Moore (not available) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joe N. Moore, Jr. / Son 6600 Hawthome Street, Landover, Maryland 20785 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗴 Burial 2 🗆 Cremation 3 🗆 Removal from State Hannony Memorial Park Oct.,05 2012 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bonnette & Associates Signature of Funeral Service Licensee CC0418 2504 28th Street N.E. Washington, D.C. 20018 23a. Eart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ATAL CARDIAL ARM Physician. disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** ONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transit MELLITUS IABETES Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicial Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 ☐ Other (specify) Pregnant at time of death Month Day Year signed by the sid be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Yes 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) မ 1 Yes 🕅 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work?
1 Yes 2 No 1 Natural 28b. Time of 28d. Describe how injury occurred injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

4514

29c. License number

D72271

29d. Date signed (Month, Day, Year)

or Cheverly mo 2078

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Lee Monroe 09 2012 9:20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Woodside Center Silver Spring Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number If Under 24 Hrs. **Funeral** 579-22-0861 **Director** 1 🗆 M 2 🗓 F 91 04/28/1921 NC Usual Residence of Decede or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits aţ Director Examiner must be notified 1 XYes 2 No Silver Spring MD Montgomery 10e. Street and Number 10g. Citizen of What Country? 23a ( Funeral 9148 Piney Branch Rd. #202 20903 "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 **X** No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: **Black** 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DQ NOT use retired)

2. S. Sheet Controller Assembler traumatic event, the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government should be filed v and Mental Hyg is marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leana Ingram Moses Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health a item 27 i 9148 Piney Branch Rd. #202 Silver Spring, MD 20903 Annie Mae Monroe/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of I Important; If ite any injury or of 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/02/2012 Landover, MD Harmony Memeorial 22. Name and Address of Facility Marshall-March Funeral Home 21. Si nature of Funeral Service Liceptee 4217 9th St. NW Washington, DC 20011 Indelin 23 part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death months shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Congestive Heart Failure Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease years Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury and -trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a I for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 X No Dav Pregnant at time of death the Linknown 9 Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Hypertension Completed 24a. Was an 24b. Were autopsy findings available Cardiovascular Accident prior to completion of cause of death? autopsy performe has Dementia 2 X No Yes 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 🗓 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury work?
1 Yes 2 No 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide within 24 hours after death

To the Funeral Director: A
completely filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my blowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar 29b. Signature and title of certific

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

John Hudson-Odoi C.R.N.P. 15245 Shady Grove Rd. Rockville, MD 20850

29c. License number

R169951

29d. Date signed (Month, Day, Year)

10/02/2012

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Ma	aryland / Depa	artment of H	ealth and M	lental Hy	giene						
		Reg. No. 20	12	33878										
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day	Year	3. Time of Death				
	Medic	al	Natalie Marie McGuire				Octobe	r 2 20	12	9:02 A.M				
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or I			4c. County						
"مو <sub>ال</sub> ينية	Funeral		311 High Gables Drive #303 5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)		ersburg If Under 24 Hrs.	8. Date of Bir	irth 9. Birthplace (State or Foreign						
	Director		016-26-7866 1 □ M 2 🗓 F	89 Yrs.	Months Days	Hours Min.	(Month, Da	onth, Day, Year) Country)						
1000	, wo		Usual Residence of Decedent				08/08/	1923	Cana					
	yland -f sho ed at	ctor	10a. State 10b. County	10c. City, Town or Loc					1	0d. Inside City Limits				
	e Mar r 28a notifi	Oire	MD Montgomery  10e. Street and Number		Gaithers	ourg				1 X Yes 2 □ No				
	ith th	rall	311 High Gables Drive #303		20878		1	10g. Citizen of V United						
	ems ?	10a. State   10b. County   10c. City, Town or Location   MD   Montgomery   Gaithersburg   10c. City, Town or Location   MD   Montgomery   10c. City, Town or Location   10c. Ci												
9	or its	by F	Armed Forces? 1 ☐ Never Married 2 💢 Married 1 ☐ Yes 2 💢 [	No If	f Yes, specify Cuban	, Mexican, Puerto	Rican, etc.)		k, White, e					
25	ural", ural",	Specify: Sp												
<u>2</u>	"nat "nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	lent's Usual Occupat kind of work done du	ion ring most of worki	ng	16b. Kind of Bu	siness/Ind	dustry				
2	thin 7	Som	Elementary/Secondary (0-12) College (1-4 or 5-	+)	O NOT use retired) istered Nu	irce		Medic	a 1	a1				
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	Be (	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle,							
an	should be file n and Mental H 7 is marked o raumatic eve	70	William Karnes			Ellen Ri			/					
aZ	hould and M s ma		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ig Address (Street an	nd Number or Rura	l Route Numbe	r, City or Town, S	tate, Zip C	ode)				
	of and 2 should be of Health and Ment: fitem 27 is marked rother traumatic e		John Richard McGuire(Spouse)	) 311 F	High Gable	es Drive	#303,	Gaithers	burg,	, MD 20878				
ore	e 1 ar of He If iten or oth		20a. Method of Disposition	20b. Place of Dispos cemetery, crem	natory or other place	1	Date	20c. Location -	City or To	wn, State				
Ě	Pagitment tant:		1  Burial 2  Cremation 3  Removal from State 4  Donation 5  Other (Specify)	Metropoli	tan	201		Alexano	lria,	VA				
Baltimore,	permit. Page 1 a Department of I Important: If it any injury or of	İ	21. Signature of Funeral Service Licensee  RACYA STUVEN Mo	22 De	Name and Address	of Facility	10 Ea	st Deer	Park	Drive,				
		_	23a. Part 1. Enter the disease, or complications that caused	the death. Do not ente	er the mode of dying,	such as cardiac o	r respiratory ar	ZUO / / rest,		Approximate				
	h sician/		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final		-£					Interval Between Onset and Death				
	Medical		reculting in death)	ocardial Ir	niarction				1	linutes				
	Examiner		Sequentially list conditions											
	A	Examiner	cause. Enter Underwing	consequence of):										
	and and	xan	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a	consequence of):										
	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial trapsit	dical E	resulting in death) Last	oonsequence on,										
20	cate to physics the	Φ.	d											
8	certifi nding use a	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of		1			23d. Dat	e of delive	ery				
ž Po	leath e atte	sicia	1 Yes 2 XNo 4 Pregnant at	Fetal death 3 L time of death 5 L	Other (specify)			Moi	nth	Day Year				
5	the c by the	Physician/M	9 Unknown											
<u>7.</u>	s that gned be de	by	Part II. Other significant conditions contributing to death but	it not resulting in the ui	nderlying cause give	n in Part I.				e cause of death?				
<u> </u>	een s	eted					1 🗆			ably 4 🗆 Unknown				
Vital Records,	law r has b je 2 s	Completed					24a. Was autop	osy p		psy findings available apletion of cause of				
ř	n: The icate ir, pag		25. Was case referred to medical				1 🗆 Yes		Yes	2 □ No				
<u> </u>	siciar certil	o Be	examiner?	ent 2 🗀 ER/Outpatien	Other	ce of Death (Check								
10	g Phy er this ieral c	e: To	27. Manner of Death 28a. Date of injury	y 28b. Time of	28c. Injury a			dence 6 Othe						
UQ Q	ending ath. rr. Afte	icat	1 X Natural 5 ☐ Pending (Month, Day, 2 ☐ Accident ☐ Investigation	Year) injury	M 1 □ Y	es 2 🗆 No								
VISION	or Atte fter de lirecto in by ti	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injurbuilding, etc.	ry - At home, farm, stre (Specify)	et, factory, office		28f. Location (S City or Tow	Street and Numbe	r or Rural	Route Number,				
5	spital ours a leral D		29a. Certifier 1 🚨 Certifying Physician: To the best of r	ny knowledge, death c	occurred at the time.	date and place, ar	nd due to the ca	ause(s) and mann	er as state	ed.				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial traps.	Medical	(Check 2 Medical Examiner: On the basis of ex only one) 3 Certifying Nurse Profitioner: To the	amination and/or investi	igation, in my opinion	, death occurred at	the time, date a	ınd place, and due	to the cau	ise(s) and manner stated.				
	vitt To t		29b. Signature and title of confifer		29c, License r D0983			29d. Date signed October						
	J		was forest	notife (Itany 200-) (T				- CCCODEI		.012				
			30. Name and address of person who completed cause of de Barry Norman Rosenbaum, M.I			re. Kens	ington	MD 208	95					
	Stat	е	31. Date filed (Month, Day, Year) 32. Registrar			2.7 2.0110		, 200						
	Registra		OCT 03 2012 Cenus	r's Signature										

12-07164 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Donnel Dandre McCov State of Maryland / Department of Health and Mental Hygiene 2012 33879 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year September 22, 2012 **Medical Examiner** 1754 hrs Donnel DAndre McCoy

4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b City Town or Location of Death Eastbound Route 50 Prince George's Landover 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In vrs. last birthday) Months Director country)Wash DC 1 X M 2 F 578-08-0977 Yrs 29 8.1983 Usual Residence of Decedent ΔII 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No show Bladensburg Md. Prince Georges Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20710 5425 Taussig Road . A Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 1 Yes 3 Widowed If Yes, Give Year 4 Divorced Specify: Black 1 Yes 2 No specify: ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Service Mgmt. conference services 12 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Sharon McCoy Be Gregory Crudup ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5425 Taussig Rd, Bladensburg, Md. 20710 Ebony McCoy - spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department of Important: I 10/2/12 Donation 5 Other Specify Chesapeake Crema. Beltsville permit. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Eternal Faith Funeral Steven L. Napor 10684 So. Md. Blvd., Dunkirk, Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical UNPENDED AMENDED attending physician or use as the burial The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown s been signed by the should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has page 2 death? performed? Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗹 Other: Scene ER/Outpatient 3 DOA After this 1 Yes 28a. Date of Injury (Month, Day Year) Sep 22, 2012 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Subject operator of motorcycle in collision with 1 Natural 1746 hrs 5 Pending 1 Yes 2 ✓ No auto 2 🗸 Accident ber, City 3

Division of Vital Records, P.O. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Suicide 6 Could not be 286. Place of	or injury - At nome, farm, street, factory, office building, et	or Town, State)												
Homicide determined (Specify)	Vlajor Road / Highway	EB Route 50, Landover, MD												
Certifier 1 CertifyIng Physician: To the best o	of my knowledge, death occurred at the time, date and pla	ice, and due to the cause(s) and manner as stated.												
	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)												
doll h. (1) M	O.C.M.E.	September 23, 2012												

With Bull Me 30. Name and address of person who completed cause of death (Item 23a)

Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State Registra

4 29a. ( (Chec Medical 29b. 5 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 1 2

		ľ	For State Registrar	State of Maryla		tificate of			Reg. No.	12	33880			
	Physicia	ın/	1. Decedent's Name (First, Middle, Las	·	37 37			2. Date of Dea Month		Year	3. Time of Death			
	Medi	cal	Joseph McNutt  4a. Facility Name (if not institution, give	aka James	McNutt			<u>Octobe</u>	r 1, 20	12	9:00 PM			
	Examir	ier	Arden Courts	street and number)			or Location of Deat r Spring	ın		4c. County of Death  Montgomery				
	Funeral		Social Security Number     6. Security Number	7. Age (In yrs.	last birthday)	If Under 1 Yea	r If Under 24 Hrs		h	9. Birthpl	ace (State or Foreign			
	Director			⊠м 2 □ F 91	Yrs.	Months Days	s Hours Min	Jan. 14		Counti NY	<b>y</b> )			
	nd how at	5	Usual Residence of Decedent  10a. State  10b. County	10c. Ci	ty, Town or Lo	ation			,		ld. Inside City Limits			
	faryla 8a-f s tified	ecto	MD P.G.		Adelph	.4					1 ☐ Yes 2 🏝 No			
	the N	٥	10e. Street and Number		Adelpi	10f. Zip Code			10g. Citizen of W	hat Count	ry?			
	h with ns 23a nust t	Funeral Director	1733 Metzerott R	oad			20782		USA					
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1   Never Married 2   Married  3   Widowed 4   Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.		Vas Decedent of f Yes, specify Cul	Hispanic Origin? (Span, Mexican, Puer o Specify:	pecify Yes or No- to Rican, etc.)		- America , White, et Whi	c.			
2-0	2 hour "natu edical	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Busine												
121	ithin 7 ene. • than he Me	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do	O NOT use retired			Paliai	0110				
d 2	Hygik Other ent, t	Triest Religion 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surmame)												
ılan	d be fi	Robert H. McNutt Elizabeth Dunn												
Maryland	should and N is ma auma	ate, Zip Co												
2,	and 2 lealth im 27 her tr	phi, MD	D 20782											
Baltimore,	permit. Page 1 s Department of H Important: If ite any injury or ot	20a. Method of Disposition    20b. Place of Disposition (Name of cemetery, crematory or other place)   20c. Location - City of cemetery												
Ball	permit Depar Impor any in once.		21. Signature of Funeral Service Licens	-0-	F22	Name and Addr	ess of Facility Collins	Funeral	Home In	c.	MD 20001			
	Physician Medical Examiner	er.	23a. Part 1. Enter the disease, or compands, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Dementia  Due to (or as a consequence)  b. Arterioscle	th. Do not ente	r the mode of dy	ing, such as cardia	c or respiratory arm	est,	1	Approximate Interval Between Onset and Death			
092	ificate be executed g physician and as the burial transit	Medical Examiner	if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq c.  Due to (or as a conseq d.										
Ö	ding rating	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of pregni 1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of g ☐ Unknown	al death 3 🗌	Ectopic pregnal Other (specify)	ncy		23d. Date Mont		y Day Year			
P.0	that the	by P	Part II. Other significant conditions co			nderlying cause (	given in Part I.	23e. Did to	bacco use contrib	oute to the	cause of death?			
ds,	quires en siç ould b	ted	General Debility	Prostate Car	icer			1 🗆 ነ	′es 2 □ No 3	B 🗌 Proba	ably 4K Unknown			
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death of within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for the funeral director.	Completed						24a. Was a autop perfor 1 \(\sum \) Yes	sy pr med? de		sy findings available pletion of cause of			
Ital	sician certif lirecto	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 ☒ No	Hospital:	FD/0:		Place of Death (Che	eck only one)  Home 5  Resid	Ass	iste	Living			
of \	g Phy er this ieral d	e: To	27. Manner of Death	1 Inpatient 2 28a. Date of injury	28b. Time of	28c. Inju	ıry at		ence 6 🔼 Other ow injury occurred					
on	ending sath. or: Aft he fur	ficat	1   Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		injury	M 1 [	rk? ] Yes 2  No							
27. Manner of Death   1														
	the Hosp nin 24 hou the Funer	Medical	(Check 2 ☐ Medical Examination only one) 3 ☐ Certifying Nurs	ician: To the best of my knowner: On the basis of examination of Practitioner: To the best of	n and/or invest	igation, in my opir	nion, death occurred	at the time, date ar	nd place, and due t	o the caus	e(s) and manner stated.			
	P S P S P S P S P S P S P S P S P S P S		29b. Signature and title of certifier  Rabert H	hard MD		29c. Licen <b>D55</b> 5	se number		October					
			30. Name and address of person who c	1500 Fores	t Glen		ilver Sp	ring, MD	20910					
	Sta		31. Date filed (Month, Day, Year)  OCT 0 4 2012	32. Registrar's Signa	ture									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registra MEND#20bperFH, 10/10/12; EMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 30 Physician/ **Φ9** Year MAGGIE 19 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 229-38-5984 **Director** 1 M 2 X 81 Sept. 17,1931 North Carolina Usual Residence of Decedent 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f MD Anne Arundel Hanover 1X Yes 2 No 10e. Street and Number 5 10f. Zip Code ms 23a oi 10g. Citizen of What Country? Funeral 7515 Lemon Tree Court 21076 United States death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or i ò 1 Never Married 2 Married and 2 should be filed within 72 hours after. Health and Mental Hygiene. Iem 27 is marked other than "natural", or 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. 3 XWidowed 4 ☐ Divorced Specify: Black Completed er than "natur, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11 ed other Housekeeping NIH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of r traumatic even မ Jackson Wiliams Mary Jane Pullen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Brinkley/Daughter 7515 Lemon Tree Court, Hanover, MD 21076 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of Date ank 20c. Location - City or Town, State Page 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 10-18-2012 | Arlington, VA Donation 5 Other (Specify) Arlington National enf Funefal Service Lice 22. Name and Address of Facility McGuire Funeral Service, Inc. 49 7400 Georgia Avenue, N.W. Wash., D.C. 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ NON SMALL LUNG (ANCE disease or condition ONCE Medical resulting in death) Due to (or as a onsequence of) Examiner Sequentially list conditions Examine d any, leading to minicul cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence oi). death certificate be executed and Due to (or as a consequence of): use as the burial signed by the attending physician تا be detached for use as the اسبت Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Pregnant at time of death Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>S</u> 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ည ER/Outpatient 3 DOA 1 🗌 Inpatient 2🗶 npletely filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number

To the Hospital or Attending Physician: The law I within 24 hours after death.

To the Funeral Director: After this certificate has be Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 9 VA 0101236858 10-01-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 Hospital Drive, Glen Burnie, MD 21061 Corey Carter, M.D. 32 Registrar's Signatu State UCT 04 2012 Registrar DHMH 17 Rev 06-2011 ORIGINAL

State of Maryland, Department of Hearth and Methial Hygiene... State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Octobe Physician/ Murra 7:18 P M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Paradise Assisted Living Catonsville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 216-22-1625 **Director** 1 🛛 M 2 🗆 F 85 Yrs 07/11/1927 MD Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No Catonsville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 USA 14 N. Beaumont Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' þ 1 Never Married 2 Married X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Yes, Give 3 X Widowed 4 Divorced White Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Sand Mining Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elva Gleatha Stotler Lawrence Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela A.Chilcoat/Daughter Beaumont Avenue Catonsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 10/09/2012 Hagerstown, MD Cedar Lawn Park Signature of Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street MO0260 Grove Funeral Home, P.A. Hancock, MD 21750-0368 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed 1 🗌 Yes Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Division 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check Fertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Box 68760

P.O.

Records,

of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9/30/2012 Physician/ 225p<sup>M</sup> Sarah Josephine O'Haran Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 419 Defense Hwy. Gambrills If Under 7. Age (In yrs, last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2XX Months Days Hours Min. 12/2871936 **Director** 577-46-6541 75 DC Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland items 23a or 28a-f sho her must be notified at Director 1 Yes 2XXNo Gambrills Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1419 Defense Hwy. 21054 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian ge 1 and 2 should be filed within 72 hours after dea nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or iten or other traumatic event, the Medical Examiner Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Yes Maryland 21215-0036 White 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates 3xxWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ Board of Education Bus Driver 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Howard Moore Charlotte Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3656 Solomons Island Rd. Harwood, MD 20776 daughter Maria Dove Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 10/5/2012 Annapolis, MD 4 Donation 5 Other (Specify) Hillcrest Memorial 22, Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of F ral Service Li On Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Ph\_sician/ weeks Sepsi disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence on keen signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law equires that the death certificate be executed Ma that initiated events Due to (or as a consequence of resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 1 ☐ Yes 2 🔀 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has t autopsy 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 📉 No Other: ျ 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After injury work? 1 Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number. completed filled in by determined building, etc. (Specify) City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 1 only one) 29b. Signature and title of certific icense number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

Dand K

Howard K

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

chalte

Dr.

35848

1438 Vefersetting

12/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Thomas Patterson 2012 01 12:30 P M October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Anne Arundel Linthicum Tate Chesapeake Hospice House If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year, Director 90 136-18-4569 1 X M 2 □ F Yrs. July 21, 1922 New Jersey show 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director notified 28a-f MD Anne Arundel Glen Burnie 1 Yes 2X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? pe ms 23a ( must be Funeral 21060 USA 6701 Rapid Water Way #201 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Bace - American Indian. Examiner Armed Forces? 1 Yes 2 No 0 Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give "natural", Specify: White 3 - Widowed 4 - Divorced Completed Year or Dates. WWII Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) Federal Government Insurance Adjuster Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ David Patterson Rose Hale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Linda Magnifico/Niece</u> Bernhards Bay, NY 13028 66 Windjammer Dr. 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from 9 4 Donation 5 Other (Specify) Metro Crematory, INC.Oct.3,2012 Baltimore, MD Signature of Fun al Service License Parranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a art 1. E ter the disease, or com dications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, heart failure. List only ne cause on each line Immediate cause (Final Onset and Death Physician/ JASC Canca disease condition resultion in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 g Unknown 2 🗌 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Ha မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury accurred 5  $\square$  Pending Natural injury 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier

State Registrar 36. Name and address of person who completed ca

55 P. Date filed (Month, Day,

DHMH 17 Rev 06-2011

of death (Item 23a) (Type, Print)

29d. Date signed (Month. Day. Year)

2017

12-07143 **Brian Proctor**  Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 33885 State of Maryland / Department of Health and Mental Hygiene

		- For State Registrar				Ce	ertifica	ate of	Deatr	1				Reg. No.					
Physician	1/	1. Decedent's Name ( BRIAN		e,Last) PROCT	OR			_				2.	Date of De Month Septemb	Day Day Der 21,	Year 2012		of Death 4 hrs		
	Ī	4a. Facility Name (if n				ımber)		41	Cheve	own, or Lo	ocation o	f Death			c. County of Prince G				
Funeral	٩.	5. Social Security Nur		6. <b>S</b> ex		7. Age (In yrs	. last birth	nday)	If Unde	r 1 Year	If Unde	r 24Hrs.	8. Date of E	Birth (MM	/DD/YYYY)	9. Birthplace (	State or		
Director		577-92-05	11	1 X M	2_F	41		Yrs.	Months	Days	Hours	Min.	10-10	0-19	70	Foreign Country)	DC		
8	- 1-	Usual Residence of D 10a. State 10	ecedent b. County			10c. Ci	v Town	or Locatio	on .							10d. Ins	side City Limits		
od how any	_ [	MD III	PG					/ILLE								1 🗶 🕆	Yes 2 No		
with the Maryland ns 23a or 28a-f show be notified at once.	Director	10e. Street and Numb	per						10f. Zip	Code				10g. Cit	tizen of Wh	at Country?			
the M	高	2730 LORR	ING D	RIVE	, APT	.#202			2	20747				US					
n with	era	11. Marital Status	. □.		. Was De	cedent Ever in orces?	U.S.					in? (Spec Puerto Ri	ify Yes or N can, etc.)	10-	14. Race · White	- American India , etc.	an, Black,		
r death	Funeral	1 Never Married		arried 1	Yes	orces?X		<b>₁</b> □	Vac. 2	X No	s pacify:				Specify:	BLACK			
rs afte	⋧	Widowed  15. Decedent's Education		10	es, Give Ye Dates: ighest gra		16a. I	Decedent	s Usual (	Occupatio	n (Give l	kind of wor	k done	16b.		siness/Industry			
2 hour	18	Elementary/Second			College (			during mo	st of wor	king life. [	TON OC	use retired	i)	1 _					
5-0036 led within 72 hours after typene. other than "natural", the Medical Examiner.	Completed	12 <b>T</b> H					RI	ECYCI	LER_						PRIVAT	E			
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (F												, Maider	n Surname)				
121 d be fi fental arked event,	RICHARD R. PROCTOR												umber, C	City or Town	n, State, Zip Coo	ie)			
MD 2 d 2 shoul lith and h m 27 is m	ှိ	LINDA JOH												2, F	FOREST	VILLE, M	ID 20747		
ore, MC es 1 and 2 s of Health ar If item 27 ther traums	1	20a. Method of Dispo						of Dispositions		ne of cem	etery,	[	Date	20c.	Location -	City or Town, S	tate		
Baltimore, bernit. Pages 1 at Department of He (mportant: If ite		1 XBurial 2 4 Donation 5			Removal f	rom State		ECTI	ON C	EMET:		9-29-			LINTO				
Baltimo permit. Page Department Important: injury or ott	ŀ	21. Signature of Fund	eral Service	Licensee		M 009	81							DECENTIFE MD 20747					
E P P E	Ť	Charles & your 5538 MARLBORO PIKE, FORE														ximate Interval			
Physician /Medical		23a. Part I. Enter the disease, o implications that are led the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he failure. List only one cause on each line.										lock, of flee	Betw	een Onset and Death					
Examiner		Immediate Cause (Fi				unshot Wo a consequence											5440		
	ı	Sequentially list cond		b		u consequence													
	iner	if any, leading to imm cause. Enter Underl	nediate		to (or as	a consequence	e of):												
	Examine	(Disease or injury the events resulting in de	at initiated	U	to (or as	a consequenc	e of):												
executed in and il - trans	Sal	UNPENDED		d	MENDED														
760, ficate be e	\/Medical	IF FEMALE:			23c. If yes	outcome of pr	egnancy							23	3d. Date of	delivery			
587 ortifica ding p		23b. Was decedent p past 12 months?		the	1 Live			2 Fet		3	Ectopi	c pregnanc	СУ		Month	Day	Year		
Box 68 e death certi the attending ed for use as	Physicia	1 Yes 2 No	9 🔲 Ur	known	· 🖂	nant at time of nown	deadi	5 Oth	ner (Spe	cify)									
D. B trthe d by the		Part II. Other signifi	cant condi	itions co	ntributing	to death but no	ot resultin	g in the u	nderlying	cause gi	ven in Pa	art I.				bute to the caus			
, P. (res that signed be det	d by												100000			Probably 4			
requi	Completed													topsy	l t	orior to completi	ndings available on of cause of		
eco he law ate has	E O												1 <b>✓</b> Ye	rformed s 2		death?  Yes	2 No		
An: T	Be C	25. Was case referre	ed to medic									(Check or							
Vita hysici	To B		No No	Hos	pital: 1	Inpatient 2				OOA 28c. Injur	Other4				dence 6 _	Other:			
ding P		27. Manner of Death  1 Natural	_	nding	Sep 2	e of Injury th, Day,Year) I, 2012		Time of I	njury		es 2 🗸	. Is	ubject s		injury occur.	- Cu			
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  *al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	O state to the control of the contro											te Number, City							
Div ital or irs afte	Certification:	3  Suicide 4 ✓ Homicide		uld not be ermined	1	/) Apartme						3	or Towr 12 37th S	n, State) treet S.	E, Washir	ngton, DC			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		29a. Certifier	Certifying I	Physician	: To the b	est of my know	ledge, de	eath occur	red at the	e time, da	te and pl	ace, and d	lue to the c	ause(s) a	and manner place, and c	r as stated. due to the cause	e(s)		
To th within To th comp	Medical	29b. Signature and t		ar	nd manner	stated.				c. License			· · ·			ed (Month, Da)			
		1.1	0,	1		MD				O.C.	И.E.			Se	eptembe	r 22, 2012			
45W		30. Name an addre	ess of perso	n who cor	npleted ca	use of death (I	tem 23a)	_											
		Melissa Bras				edical Exa		-		more S	treet, E	Baltimore	e, MD 21	1223					
St Regist	ate trar																		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ Month O Medical 4a. Facility Name (if not institution, give str et and number) Examiner 4b. City, Town, or Location of Deat of Death a If Under Birthplace State or Foreight Country) **Funeral** 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. Director 1 X M 2 □ F or than "natural", or items 23a or 28a-f show the Wedical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Jode 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Very Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examina 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: 3 Widowed 4 □ Divorced Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 011 Be 17. Father's Name First, Middle, Last, 18. Mothe r's Name (First, Middle, Matt n Sumame Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other p 20c. Location - City or Town, State 1 | Burial 2 | Cremation 3 | Removal from State 4 | Donation 5 | Other (Specify) 6 21. Signature of Funeral Gervice Licensee 22. Name and Address of Faci 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine ng physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) To the Hospital or Attending Physician: The law requires tnat the cean within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the are completely filled in by the funeral director, page 2 should be detached formula the funeral director. 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \( \triangle \) Nursing Home 5 \( \triangle \) Residence 6 \( \triangle \) Other (Specify) 1 Tes 2 1No ဥ 1 -Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0060100 MD 35:11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MALMINA K 831 1 Univers L BLUD Sous L Silve Mrg 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

0 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 29, 2012 2330 Kathryn Pryor Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Prince George's Chever1v 5. Social Security Number Year If Under 24 Hrs. If Under 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Min. (Month, Day, Year) **Director** 577-30-4156 1 M 2 X F Usual Residence of Deceden July 28, 1915 Virginia 28a-f shov 10c. City, Town or Location must be notified at 10d. Inside City Limits Director Washington 1 X Yes 2 No DC 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 5000 Nannie Helen Burroughs 20019 United States or items filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", **Black** Completed 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) if Health and Mental Hygiene, item 27 is marked other than Elementary/Secondary (0-12) 12th College (1-4 or 5+) Housekeeping Private other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Page 1 and 2 should be James Williams Bertha unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlissa Tomlinson - Niece 215 54th Street NE Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Oct. Date 0. permit. Page 1
Department of
Important: If it
any injury or o cemeter, crematory or other place)
National Cemetery 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2012 Triangle, Virginia 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Stewart Funeral Home, Inc. M00560 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami burial-transi and physician is the buria Physician/Medical that the death certificate be P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ō in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death the Unknown signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 performed certificate 1 Yes 2 No Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) n 24 hours after deam. he Funeral Director: After this ce noletely filled in by the funeral dire 2 No Other: 1 Yes 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Of the basis of examination and/or investigation in my action. Medical 29a. Certifier If the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: C within 2 3 Certifying Nurse Pra 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 06-2011

State

JUN

me and address of person who comp

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33888 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death October 29y 2012ear PAUL Physician/ Alan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location Bethesda Examiner or Location of Death 4c. County of Death 8300 Burdette Rd. Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign
 Country) **Funeral** 7. Age (In yrs. last birthday) )ct. 6. Days Hours Min 076-22-3541 82 New York 1 X M 2 □ F **Director** 10c. City, Town or Location Bethesda at 10a. State 10b. County 10d. Inside City Limits with the Maryland Director ms 23a or 28a-f s must be notified Montgomery MD 1 🗆 Yes 2 💆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20817 8300 Burdette Rd. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items? any, injury or other traumatic event, the Medical Examiner must once. 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 No
If Yes, Give Korean 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🕅 No Specify Korean Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Liquor Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Hannah ၉ Paul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Paul / son 11412 Twining Lane, Potomac, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Pinelawn, NY Wellwood Cemetery Oct. 4, 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Funer Pervice Licens 20012 he 254 Carroll St., NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Respiratory Failure Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cardiac Failure Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): use as the burial ding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for 5 Other (specify) Pregnant at time of death Month Day Year been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed? death? 1 Yes 2 No Yes 2 K No funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 💢 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) assisted after death. Director; After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred livino 1 Natural 5 Pending 1 Yes 2 🗆 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral C Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29b. Signature and title of certifie 6 060168 October 2, 2012 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20854 1201 Seven Locks Rd. #111, Rockville, MD Asefa Mekonnen, MD 31. Date filed (M Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33889 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 21,2012 10:25 PM <u>Felix</u> J. Popielski September Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Director <u>034-14-573</u>1 1 🕱 M 2 🗆 F Oct. 27,1927 Usual Residence of Dece ጸፈ Massachusetts filed within 72 nous ..... tal Hygiene ed other than "natural", or items 23a or 28a-f show e event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Directo 1 X Yes 2 No D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20011 3700 North Capitol Street, North West United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 X Yes 2 No 1945 If Yes, Give 1965 Black, White, etc. 1 X Never Mamed 2 Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed 3 Widowed 4 Divorced Specify: Caucasian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Air Force Staff Sergeant Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file f Health and Mental F item 27 is marked o ည Stanley Popielski Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
555 Newcomb Street, South East
Washington, District of Columbia 20032 item 27 i John Gloster/Attorney 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 s
Department of H
Important: If ite
any injury or ot Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 10/12/2012 Beltsville, Maryland 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, North West Washington, District of Columbia 20012 21. Sanature of Funeral Service Lidensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Enysician Onset and Death disease or condition Sepsis Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or Injury Pneumonia Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Respiratory Failure that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical P.O. Box 68760 Advanced Dementia attending p IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Day Year ed by the a 9 Unknown signed by t Id be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, been sig Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? After this certificate funeral director, pag 1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 1 Yes 2 🔀 No Certificate: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 X Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 5+1 machic-D66372 September 23, 2012

Registrar

DHMH 17 Rev 06-2011

State

1500 Forest Glen Road, Silver Spring, Maryland 20910

Name and address of person who completed cause of death (Item 23a) (Type, Print)

<u>Majid Rahmanian Shahri</u>

31. Date filed (Month, Day, Year,

OCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year  $9^{\text{Month}}_{-25-12}$ THOMAS SYLVESTER QUEEN P 9:41 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3606 BLACKWATER ROAD CLINTON PG 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. (Month, Day, Year, 578-18-2601 91 1 **X** M 2 □ F Director -9 - 1921DC Usual Residence of Decede 28a-f show 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Oa. State 10c. City. Town or Location Director MD PG CLINTON 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3606 BLACKWATER RD 20735 US 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: BLACK 1 Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry الم filed win. مجلط Hygiene. خو**r than "r** Elementary/Secondary (0-12) 12TH College (1-4 or 5+) SPECIAL DELIVERY POSTMAN PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ပ JOHN QUEEN MARY AGNES BROWN traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau SYLESTINE MORTON/DAUGHTER 3606 BLACKWATER RD, CLINTON. MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State ARYLÁND NÁTIONAL 10-2-2012 LAUREL, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 21. Signature of Funeral Service Li 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DEBILITY disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to jor as a consequence of cause. Enter Underlying Examin Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last physician sthe buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year 5 Other (specify) Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 X No has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 🗶 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify, 1 \( \text{Yes} \) 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5  $\square$  Pending X Natural Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) Kouatcheu, m! D63748 Jocelyne 6-5M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

JOCELYNE KOUATCHOU,

31. Date filed

M.D.

4041

2. Registrar's Signature

POWDER MILL RD, BELTSVILLE, MD 20705

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Obisor Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Arunde Medicul Age (In yrs. las Funeral 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Hours Country) Director 579-48-3969 77 1 🗶 M 2 🗆 F Dec. 14,1934 Minnesota nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland arment of Health and Mertal Hyglene. ordant: If tien 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Arnold 1 🗆 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 21012 525 Augusta Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", Specify Completed 3 - Widowed 4 - Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Nabisco Brands Elementary/Secondary (0-12) College (1-4 or 5+) Sales Representative Cookie Company 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Marcella Marie Potvin Henry L. Robison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 525 Augusta Drive Arnold, MD 21012 Betty J. Robison / Wife Baltimore, permit. Page 1 to Department of Ht. Important: If item any injury 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) October 02 Metro Crematory, Baltimore, MD INC. 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Fu service Licensee Name and Address of Facility CREMATION DIRECT 495 Ritchie Hwy Severna Park, MD 21146 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) piratory Medical **Examiner** Sequentally list nonditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed ician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical P,O, Box 68760 as IF FEMALE: asn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death 5 Other (specify) Month Day Year signed by the ar Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page perform Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita Other: 은 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending nours after death. neral Director: Al filled in by the fu 1 Yes 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours of the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Decertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 0 of death (Item 23a) (Type,

Registrar
DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7 State of Maryland / Bepartment of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Douglas October F. Redmond 2012 8:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 4c. County of Death Examiner Hamilton Center Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 05-21-1920 230-12-4793 Days Hours Virginia Director 1X M 2 □ F 92 Usual Residence of Decedent er than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10c. City, Town or Location Baltimore 10d. Inside City Limits 10a, State within 72 hours after death with the Maryland MD ¹X☐ Yes 2 ☐ No ā the Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21214 6040 Harford Rd. USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? 1 X Yes 2 No 1942 Black, White, etc. 1 Never Married 2 Married ፩ Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 X Divorced Completed 1946 Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Private Supply Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Marv Muse permit. Page 1 and 2 should rep Department of Health and Mental Important: If item 27 is ne-any injury or other Mary Redmond Jeremiah 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 705 Bonnie Meadow Ln. Ft. Washington, MD 20744 19a. Informant's Name/Relationship (Type, Print) Patricia Britton/Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State Garrison Forest Vet. 10-31-2012 Owings Mill, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ronald Taylor II FH 21. Sonatur of Funeral Service License Hansel 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying sician and burial-transit Cause (Disease or in that initiated events Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year 1 Yes 2 No certificate has been signed by the a irector, page 2 should be detached t 9 Unknown Hospital or Attending Physician: The law requires that the 24 hours after death. Funeral Director: After this certificate has been signed by the telly filled in by the funeral director, page 2 should be detachetely filled in by the funeral director, page 2 should be detachetely filled in by the funeral director, page 2 should be detachetely filled in by the funeral director. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 8c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed cause of death (Item 23a) (Type Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 33893 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Ruth D. Rettaliata 2012 10:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard Light House Assisted Living Ellicott City If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Country) 217-12-3026 **Director** 1 M 2 X F 89 Yrs 03/23/1923 MD ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Cooksville MD 1 Yes 2 No Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4820 Cemetery Lane 21723 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White Year or Dates Ith and Mental Hygiene.
27 Is marked other than "nature traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ be Emma Marie Kronenberg John A. Dorsey the Page 1 and 2 should by thent of Health and Mertant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beth Lawson - Daughter 4820 Cemetery Lane Cooksville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place ō 1 Burial 2 Cremation 3 Removal from State permit, Page Decartment Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Cremation Center of Mb 10/08/12 Hanover, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ hermos disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 D Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown To the Hospital or Attending Physician: The law requires the contributed hours after death.

To the Funeral Director: After this certificate has been signed by the arm of the funeral director, page 2 should be detached i 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No 2 No 1 🗌 Yes Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Spec 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check ical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Dertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tile of ce CMD of person who completed cause of death (Item 83a) (Type, Print) Name and add Colubia 10 avil 42115 141 32. Degistrar's Signature 31. Date filed (Month Day, Year) State OCT 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Month Jacob Rose, Joseph рм October Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 204-38-1722 Hours **Director** 1 № M 2 🗆 F 63 Usual Residence of Decede 29, 1949 PA or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 21 No MD Montgomery Bethesda 10e. Street and Number 10g. Citizen of What Country? Funeral 10213 Arizona Circle 20817 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates, 1969-75 1 ☐ Yes 2 A No Specify: Specify: White 3 Widowed 4 Pivorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) News Photographer W.TT.A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William B. Rose Cecilia A. Zaborowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly Aubry Rose/Daughter 13700 Maple Sugar Lane, Herndon, VA 20171 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Oct. 6, 2012 Burtonsville Union 4 ☐ Donation 5 ☐ Other (Specify) Burtonsville, MD 21. Signature of Funeral Service Licensee

PRANCES of Facility TINS FUNERAL IS 500 University Blvd. W. Si

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. FRANCTSA COLLUNS FUNERAL HOME INC 500 University Blvd. W., Silver Spring. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Septic Shock Medical resulting in death) Due to (or as a consequence of): Examiner Small Bowel Infarction 5 hrs Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) e burial-trapeit Small Bowel Obstruction Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 □ No 9 Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPD, Status Post Aortic Valve Replacement and Records, 1 Yes 2 No 3 Probably 4 Hhknown Coronary Bypass, Chronic Steroid Use for Lung Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 DkNo director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☒ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director, After this completely filled in by the funeral director. 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) ð 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division 2 Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Programmer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License numbe 10+1 October 2, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Siegenthaler, MD 8600 Old Georgetown Road, Bethesda, MD 20814 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

OCT 04 2012

DSEPH

CoB

1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 for State Registrar 33895 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:00 PM Still Mary Brock 29 2012 eptember Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. Social Security Number Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) (Month, Day, Year) Country) 494-16-1112 Director 94 1 🗆 M 2 🟋 F Sept. 19,1918 Missouri Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD Anne Arundel Severna Park 1 Yes 2 X No 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 21146 USA 41 W. McKinsey Road Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc 5 þ 1 Never Married 2 X Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill of Health and Mental item 27 is marked o ပ Maynor Davis Brock Madalyn Pinkston Brock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 262 Michener Court W. Severna Park, MD 21146 Peter Bergstrom/ Son-in-law 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State . Page 1 Department of Important; If it any injury or o once. cemetery, crematory or other place) October 02, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC. Baltimore, MD 2012 . Signature of Funeral Service Licensee CREMATION DIRECT 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Exter the visea, export on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or have allure. First end, one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ ementio Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) inding physician and use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23d Date of delivery in the past 12 months?

1 Yes 2 No Month the 9 Unknown Unknown g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy perform certificate Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဂ္ 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manger of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title of certifier

Registrar DHMH 17 Rev 06-2011

State

Box 68760

P.O.

Records,

Division of Vital

8601 Veterans Hwy

57531

October 1, 2012

Millersville

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nohit Negi

31. Date filed (Month, Day, Year)

				Plea							Ensure /		-		_	le.		
		1	For State		Stat	e of Ma	arylan		artme e <i>rtifica</i>		lealth and	Ment	-	•	00	. 0	0.0	000
48			Registrar  1. Decedent's Nam	e (First Middl	le Last)				HIIICa	le oi	Dealli	2 Da	ate of De	Reg. No	20	12	3 Time	of Death
Phys /Me	iciar dica		SUZANNE 1	MARY SO	DLOMON								onth	30/2	2012	Year		38 A <sup>M</sup>
Exan	ninei		4a. Facility Name (/				O DINTO	T.D.			r Location of Deat	h						
<u> </u>			ENVOY OF  5. Social Security N		6. Sex			上K last birthday	DEN o If Under	TON er 1 Year	If Under 24 Hrs	. 8 Da	ate of Bir		AROLI		ace (Stat	o or Foreign
Funera Directo		- 1	219-30-33		1 M 2 Ž		78	Yrs.	Months		Hours Min	(M	10nth, Da 7/19	v. Year	B	Count AT.TT	MORE	e or Foreign
	· .	1_	Usual Residence of		l							77	., .,				TOTAL	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
ırylan show			10a. State	10b. County	'		10c. City	, Town or l	ocation.							10		City Limits es 2 X No
ne Ma 8a-f s atifie	1	2	MARYLAND		INE		DEN	TON										es 2 (23) NO
with ti	Ë	5	10e. Street and Nu		OT THE					ip Code 629					tizen of Wh CED S			
be filed within 72 hours after death with the Maryland half Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Financial Director	2	420 COLOI	NIAL DI		Decedent I	Ever in U.	S. 13			lispanic Origin? (S	Specify Y			14. Race			
fter d r iten iner	2	3	1 ☐ Never Marr	ied 2∐ Mar	ried 1 □	ed Forces? Yes 2 <b>1</b> 711					lispanic Origin? (S an, Mexican, Puei	to Rican,	, etc.)			White, 6		
ours a	È	2	3 ☐ Widowed	4 Divorced	if Year	s, Give or Dates:			1 🗌 Yes	2 <u>K</u> J No	Specify:				Specify:	WHI'	TE	
72 hc natul	Completed	ונים	(Spec	15. Deceder	nt's Education	eted)		16a. Dec	edent's Us	ual Occur	eation during most of wo d)	rkina		16b. K	and of Bus	iness/Ind	lustry	
/ithin ne. han "	1		Elementary/Seco		<del></del>	ege (1-4or 5	i+)				d) 0	J			3. M. A. T. T.	GAT:	E.G	
iled w Hygie ther t			17 Father's Name	(First Middle	l ast)			SALE	S CLE	KK	18 Mother's Na	me (First	t Middle		ETAIL		ES	
0 = 0 %	17. Father's Name (First, Middle, Maiden Surname) ROBERT V. SCHWARTZ  18. Mother's Name (First, Middle, Maiden Surname) THELMA M. GILB											,						
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	F	-	19a. Informant's N			t)		19b. Mai	ling Addres	ss (Street	and Number or Fi		_	er, City	or Town, S	tate, Zip	Code)	
and 2 ealth a m 27 Is			HARRY SO	LOMON/S	SON			2350	6 ELK	GRO	VE TERRA	CE,D	AMAS	CUS,	MD 2	0872		
of Hei		1	20a. Method of Dis				20b. P	lace of Disp	osition (Na	ame of	cel	Date		20c. L	ocation - C	ity or To	wn, State	
Pages nent of l ant: If ite			1 ☐ Bunal 2]	K_ICremation 5 ☐ Other (5	3 □Removal Specify)	trom State	CHE	SAPEA TER	KE CR	EMAT.	10N 10/	8/20	12	STI	EVENS	VILL:	E, MI	D
permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev	je je		21. Signature of Eu	uneral Service	Liconsee	,		п	22. Name a	and Addre	ss of Facility LA	STIN	G TR	IBUT	ES B	Y FE	LLOW	S PF
# <b># 5 5 %</b>	히		Sp	THE	1-1.						& NEWNA				MD 2	1401		
	8				r complications t only one cause	that caused on each lir					ng, such as cardia			ırrest,			Approxin Interval E Onset ar	Between
Physicia // /Medica			Immediate Cause disease or condition resulting in death)	(Final on	a	FN			SE	X	imen	111	4				YEA	RS
Examine	_				Di	ue to (or as	a consequ	uence of):										
	i i	5	Sequentially list co if any, leading to in cause. Enter Under	nditions, nmediate	b	ue to (or as	a consequ	uence of):										
executed in and ial-transit	Fvaminor		that initiated events	s	<b>S</b> c													
e exer ian ar urial-t	ŭ	Ě	resulting in death)	Last	Du	ue to (or as	a consequ	uence of):										
The law requires that the death certificate be executed atte has been signed by the attending physician and age 2 should be detached for use as the burial-transit	1	2			d													
Sertific ding p	Dhyeician/Madica		IF FEMALE:		23c If vo	s, outcome	nf pregna	incv		-								
eath c attendefor us	ig	2	23b. Was deceden	months?	1 🗆	s, outcome Live birth Pregnant at	2 Feta	I death 3	□Ectopic		/				23d. Date Mont		ry Day	Year
that the de ned by the a detached t	Nei/	2	1 ☐ Yes 2 ☐ 9 ☐ Unknown			Unknown		0		4001. <b>y</b> 7 _								
s that ned b	2		Part II. <b>Other signi</b>		•	•				cause giv	en in Part I.	2	3e. Did 1	tobacco	use contrib	oute to th	e cause o	of death?
w requires to be signed should be	7		ATHLEOS	sleept	IC CA	20106	IASC	4244	2 D	155A:	34		1 🗆	Yes 2	No 3	B 🗌 Prob	ably 4	∐Unknown
e law re has bee	40	200										2	4a. Was		24b. W	ere autor	psy finding	gs available
The l	Completed	5										1		ormed? 2 LAN	de	eath?	npietion o 2 □ No	or cause or
hystcian: The his certificate I I director, pag	Bo		25. Was case referexaminer?	rred to medica						Tau	26. Place of De	ath (Che	eck only	one)				
Physic this c	F	2	1  Yes 2 1		Hospital:	1 Inpatie		ER/Outpati			4 Nursing			_			1)	
ding Ph h. After th funeral		5	27. Manner of Deal	5 □ Pendii investi	ng	Date of Inju (Month, Da		28b. Time Injury		28c. Injui Wor	yat k? Yes 2∐No	280. L	Describe	now inju	iry occurre	a		
affer death after death Director:	i i	2	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could	not be 28e.	Place of inju	ury - At ho	me, farm, s			100 2 110	28f. Lo	ocation (	Street a	nd Numbei	r or Rura	l Route N	lumber.
pital or At ours after d reral Direct filled in by	Cortification.		4 ☐ Homicide	detern	illied	building, et	c." (Specify	v)				C	city or To	wn, Stat	e)			
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certified completely filled in by the funeral director, I	Madical		29a. Certifier (Check only one)		Examiner: On		f examina				me, date and place							se(s)
To the Hos within 24 hc To the Fun completely	Mod		29b. Signature and	I title of certific	- 1	Thanner sta	ateu.		2	9c. Licens	e number			29d. Da	ate signed	(Month, I	Day, Year	r)
->-o			M	a The	1 LA	- NT	7420	ine M	11 11	300	2309	4		1	0-7	-70	117	
111		-	30. Name and add	ress of persec	who completed	cause of d	eath (Item	23a) (Type	e, Print)		1	<u>,</u> \.	C	\/\	0-2 ALSB		1/1	AN
MO	State		31. Date filed (Mor	nth, Day, Year,	4 2012	32. Registr	ar's Signa	ture	berk	ノン	68ALL	かつと	NZ!	2261	Jr J B	426	171	111)
Regi	straı	r		OCT O	4 2012	Lever		1. 4										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Noah Idan Stein PM Medical (if not institution, give street and number of Death **Examiner** 4c. County of Death N/A 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 048-67-1986 Director 1 🎽 M 2 □ F 0 9/5/2012 MD 22 28a-f show 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits Director Howard Elkridge MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 4813 Yellow Owl Ct 21075 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ģ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ¥ Yes 2 ☐ No Specify: Completed 3 Widowed 4 Divorced Cuban Hispanic of Health and Mental Hygiene.
item 27 is marked other than "natu
other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/ABe Page 1 and 2 should be filed ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joshua Howard Stein Claudia Elena Velasquez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joshua Howard Stein/father 4813 Yellow Owl Ct Elkridge, MD 21075 Department of Healt Important: If item 2 any injury or other i 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 10-1-2012 Hanover, MD Cremation Center of MD 21. Signature of Funeral Service 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on seeh life. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exam Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death PUN NOWN Division of Vital Records, P.O. I signed by t d be detach 23e. Did tobaccq use contribute to the cause of death? þ 2 No Completed 1 Tyes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autops perforr death? 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 0 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title

Registrar
DHMH 17 Rev 06-2011

State

Caton Ave Baltimore MD

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ikey Staton Sr. Month 10 2012 11:11A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Ρ G If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 243-50-2818 (Month, Day, Year) Director 76 1 XM 2 □ F N C 12-23-1935 Usual Residence of Decedent 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location Funeral Director 10d. Inside City Limits Suitland MD Р G 1 ☐ Yes 2 🔀 No 10e Street and Number 2601 Shadyside Ave. 10f. Zip Code 10g. Citizen of What Country? 20746 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 You Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: 3 Widowed 4 ☐ Divorced If Yes, Give Completed Year or Dates It of Health and Mental Hygiene.
If item 27 is marked other than "natur or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Dispatcher Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 UnKnown Ella Mae Staton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nadine Plummer (Daughter) 2601 Shadyside Ave. Suitland MD. 20746 20a. Method of Disposition
1 ☐ Burial 2 🌣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Crem cernetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 20c. Location - City or Town, State 10-5-2012 Riverdale MD. Riverdale Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hunt Funeral Home CC353 908 Kennedy St. N.W. Wash, Trance Tunt 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final thero sulerutic Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for sels nonequanes of: attending physician and for use as the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day signed by the at Id be detached fo Year ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by been sig 1 Yes 2 No 3 Probably 4 Nhknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death. Ieral Director: After this certificate has I filled in by the funeral director, page 2 s autopsy performed? 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No 잍 Other: 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours af To the Funeral Di completely filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10/03/1 no?

State Registrar 31. Date filed (Month, Day, Year,

42012

35M

ss of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

		Please Teach	Type or Print State of Man							jible.			
		State Registrar			rtificate of			Reg.	0.0	12	33899		
Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Month	Death	Day	Year	3. Time of Death		
Medic		HAL		SALA	<u>M</u>		Octob	er		012	9:12P M		
Examin	er	4a. Facility Name (if not institution, give s	ŕ		4b. City, Town,				4c. County	_			
Euporal		4601 29th St., 5. Social Security Number 6. Sex		yrs. last birthday)	Mt. R	ainier ar   If Under			Princ		rge's place (State or Foreign		
Funeral Director			M 2 <b>X</b> □ F	60 Yrs.	Months Day			Day, Yea 29, 1	951	Coun	York		
N .		Usual Residence of Decedent											
ied a	Director			Oc. City, Town or Lo						1	0d. Inside City Limits  1 X Yes 2 No		
or 28a notif	Dire	Maryland   Prince Ge	sorge s	Mt. Rai	10f. Zip Code	9		100	Citizen of	What Cour			
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	eral	4601 29th St	t.,Apt#1			20712		l rog.		JSA	шу:		
items er mu	Fun	11. Marital Status	12. Was Decedent Ever Armed Forces?				gin? (Specify Yes or I	No-		e - Americ			
", or camin	by	1 Never Married 2 Married	1 Yes 2 X No		1 ☐ Yes 2 🛣 N				Specify	ck, White,	<sub>etc.</sub> 1ack		
atural sal Ey	eted	3 Widowed 4 X Divorced  15. Decedent's Edu	Year or Dates.						1 ' '				
n "ng Medic	Completed	(Specify only highest grad	le_completed)	(Give	dent's Usual Occ kind of work don OO NOT use retire	e during mos	t of working	166	. Kind of B	usiness Ind	dustry		
giene er th	e Co	Elementary/Seconday (0-12)	College (1-4 or 5+)	Me	ntal He	ealth_	Aide		Gove	nmen	t		
tal Hy d oth event	To Be	17. Father's Name (First, Middle, Last)	-			1	er's Name (First, Mid			e)			
d Men narke natic	Alphonza L. Martin Rosie Lee Hayes  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip												
th and		19a. Informant's Name/Relationship (Type, Print)  Majah K. Anderson (Daughter)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town  15308 Jennings Lane, Bowie, MD 20									Code)		
f Heal item (		20a. Method of Disposition	<u> </u>	20b. Place of Dispo	osition (Name of		Date		Location -		own, State		
nt: If		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	remetery, creating Ft. Lince	matory or other p oln Ceme	terv 1	.0/12/2012	- 1	rentw		•		
partr porta y inju ce,		21. Signature of Funeral Service License	• /2 C(	CO341 2	2. Name and Add	ress of Facilit	ty Jordan						
ᇫᇀᄩᆁ		1 2) 3.	.//-	4	001 Benn	ing Ro	1.,N.E.,	Wash	ingto	on, Do	C 20019		
		23a. Part 1. Enter the disease, or confinence, or heart failure. List only one	cations that caused the cause on each line.	e death. Do not ent	er the mode of dy	ying, such as	cardiac or respirator	arrest,			Approximate Interval Between		
ysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	_	Onset and Death									
caminer		Toolaing in addition	Due to (or as a co	onsequence of):			1				& Months		
	ner	Sequentially list conditions, if any Leading to an addata cause. Enter Underlying		0 ( 0 ( 0 )									
and I-transit	=xamine	Cause (Disease or linjury that initiated events	>										
sian al urial-t	_	resulting in death) Last	Due to (or as a co	onsequence of):									
physic the b	Physician/Medical		í							+			
nding Ise as	Ž	IF FEMALE: 23b. Was decedent pregnant 23	3c. If <u>ye</u> s, outcome of p						23d Da	te of delive	20/		
e attel	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 4 Pregnant at tin		☐ Ectopic pregna ☐ Other (specify)					nth	Day Year		
by the	Phys	9 Unknown	9 Unknown						1				
igned be de	by	Part II. Other significant conditions con	tributing to death but n	not resulting in the i	underlying cause	given in Part	1				e cause of death?		
hould	etec				a contraction of the contraction		(1)						
has l	Completed						24a. W	as an itopsy erformed	?	prior to coi death?	osy findings available mpletion of cause of		
ifficate or, pa	Be Co	25. Was case referred to medical			26.	Place of Dea	th (Check only one)	es 2 🖫	No	1 🗌 Yes	2 No		
is cer direct	To B	examiner? 1 Yes 2 No	ospital: 1  Inpatient	2 ER/Outpatie		Ale a	ursing Home 5	esidence	6 ☐ Othe	er (Specify	)		
fter th		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Ye	28b. Time o injury	wo	ury at ork?	28d. Describ						
death	Certificate	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury -	At home form str		Yes 2		- /044			Davida Marada		
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the aftending physician completed filled in by the funeral director, page 2 should be detached for use as the burial		4 ☐ Homicide determined	building, etc. (S		eet, factory, offici	5		Town, Sta		er or <b>H</b> urai	Route Number,		
hours uneral od fille	Medical	29a. Certifier 1 Certifying Physic	cian: To the best of my	knowledge, death	occured at the tin	ne, date and	place, and due to the	cause(s)	and mann	er as state	d.		
the Fi	Mec	only one) 3 Certifying Nurse									use(s) and manner stated.		
cor cor		29b. Signature and title of certifier  29c. License number  29d. Date signed (Mo I o o S)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Daya Sharma 1400 Forest Glen Rd 435 Silver Spring  31. Date filed (Month Day Year)									Day, Year)		
105M		30. Name and address of person who cou	mploted sauce of death	/ltom (20) /Time !	Drint)	سر دد(	(		1 -	-1-	121		
-7.1M		Dr. Daya Shar		Forest	- Glen	Rd +1	135 Sil	ver	Spr	ing 1	nd 209,0		
Stat		31. Date filed (Month, Day, Year)	32. Registrar's						-				

State Registrar DHMH 17 Rev 7/2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	Z	State of Maryland / Department of 1-For State Certificate of Registrar		Nglene 2012 3390						
Physici cal Exami	an/ iner	OOSC LITSCO Sanchez		2. Date of Death Month Day Year September 25, 2012  3. Time of Death 0103 hrs						
		4a. Facility Name (if not institution, give street and number) 1710 Lebanon Street	b. City, Town, or Location of Death Hyattsville	4c. County of Death Prince George's						
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  216-19-3700 1 X M 2 F 43 Yrs	If Under 1 Year If Under 24Hrs Months Days Hours Min	1- ' '						
and show any nce.		Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Locati  Md  Prince George's Hyattsvill		10d. Inside City Limit						
Marylan r 28a-f si	Director	Md   Prince George's Hyattsvill	10f. Zip Code	10g. Citizen of What Country?						
be filed within 72 hours after death with the Maryland ntal Hygiene.  ked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	Funeral D	11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	20783 Decedent of Hispanic Origin? (Sis, specify Cuban, Mexican, Puerto	El Salvador  pecify Yes or No- Rican, etc.)  El Salvador  14. Race - American Indian, Black, White, etc.						
hours after "natural", o	by	3 Widowed 4 Divorced of Yes, Give Year 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Yes 2 No specify: E1 s Usual Occupation (Give kind of v st of working life. DO NOT use reti							
d 2 should be filed within 72 hours after lith and Mental Hygiene. n 27 is marked other than "natural", numatic event, the Medical Examiner.	Completed	9th Labor 17. Father's Name (First, Middle, Last)		Construction (First, Middle, Maiden Surname)						
2 = 5 G	To Be		Address (Street and Number or F	Eusebia Gonzalez Rural Route Number, City or Town, State, Zip Code)						
Pages I and 2 shoument of Health and N taut: If item 27 is n or other traumatic			ion (Name of cemetery,	Date 20c. Location - City or Town, State						
permit. Pages I and 2 shoul Department of Health and IN Important: If item 27 is m injury or other traumatie		21. Si nature of Euneral Service Licensee 22. N	me and Address of Facility JO	/08/12   El Salvador hn T. Rhines Funeral Home						
ysician Medical caminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	e mode of dying, such as cardiac o	Washington D.C. 20017 respiratory arrest, shock, or heart Between Onset and Death						
cuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Chronic Alcoholism with Cirrhosis of the Liver  Due to (or as a consequence of):  c.  Due to (or as a consequence of):  d.								
e be execut ysician and burial - tra	ledical	UNPENDED AMENDED								
e death certificate the attending phy ed for use as the	-21	past 12 months?	I death 3 Ectopic pregna	23d. Date of delivery  Month Day Year						
ires that the signed by th	ā	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ✔ Unknown						
certificate has been ector, page 2 should	Completed			24a. Was an autopsy performed?  1 ✓ Yes 2 No  24b. Were autopsy findings available prior to completion of cause of death?  1 ✓ Yes 2 No						
ing Physician: After this certi funeral director	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient  27. Manner of Death 28a. Date of Injury (Month, Day, Year)  Natural 5 Pending		only one) g Home 5 Residence 6 V Other Scene 28d. Describe how injury occurred						
vithin 24 hours after death  To the Funeral Director: completely filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street (Specify)	factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
To the Ho within 24 I To the Fu	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurre (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	d at the time, date and place, and no, in my opinion, death occurred at	due to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)						
2		29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) September 25, 2012						
		30 Name and address of person who completed cause death (Item 23a)  Russell Alexander MD. Assistant Medical Examiner 900 V  31. Date filed (Month Day Year) 2012	/. Baltimore Street, Baltim	ore, MD 21223						

			Plea	se Type o	r Prir	nt in I	Black In	delib	le ink	k. Ens	sure A	II Copi	es Ar	e Leg	jible.		
		For State		State	of Ma	arylan	d / Depa				and N	/lental F	lygien	e	10	0.0	
	_	Registrar	- Finh hainlelle	( oot)			Cer	tificat	e of E	eath			Reg. N	10. <u> </u>	112	<del>- 33</del>	39U
Physicia	n/	1. Decedent's Name Paul I	e (First, Middle Hsiang	Sun								2. Date of Month Septe:		ay 3	2012	3. Time 4:00	of Death  A M
Medic Examin		4a. Facility Name (if			mber)			4b. City,	Town, or	Location	of Death	Septe		c. County		1 4.00	- A ···
_Admin		Montgomer	-	age Healt	th C	are	Center					ge		,	gomen	су	
Funeral		5. Social Security Nu		6. Sex	7. Age	(In yrs. la	ast birthday)	If Under Months	r 1 Year Days	If Unde Hours	Min.	8. Date of (Month,	Birth Day, Year)		9. Birthp Coun	place (State	or Foreign
Director		229-13-85 Usual Residence of		1 <b>№</b> M 2 🗆 F		98	Yrs.					Dec.	20, 1	1913	Chi	na	
rland F shov	tor	10a. State	10b. County			10c. City	y, Town or Loc								1	10d. Inside (	City Limits
Many 28a- notifie	Director	MD		gomery			Ga	ithe		rg							es 2 X No
ith the		10e. Street and Num		Court, A	pt.	201		10f. Zip	208	78					What Cour Stat	-	
eath w	Funeral	11. Marital Status		12. Was Dec	edent Ev		s. 13. V	Vas Deced			igin? (Spe	ecify Yes or N Rican, etc.)	_	_		can Indian,	
fter de	by	1 Never Marri		ried Armed Fried 1 Yes	2 X 1	No		Yes, spec				Rican, etc.)			ck, White,		
ours a	Completed	3 Widowed		Year or C						* 1111 *	•		1		Asia		
72 hd	mple		cify only highe	st grade completed				ent's Usu ind of wo DNOT use	rk done d	ation <i>uring</i> mos	st of work	ing	16b.	Kind of B	usiness/Ind	dustry	
withir giene ier tha		Elementary/Seco	ondary (U-12)	College (	1-4 or 5-1	+)	Banke						Ва	nkin	g		
filed tal Hy d oth event	To Be	17. Father's Name (F	First, Middle, L	ast)						18. Moth	ner's Nam	e (First, Midd	dle, Maider	n Surname	e)		
uld be d Men narke natic	-	Unknown	(D. I. II. I							Unkn							
2 sho Ith and 27 is i		19a. Informant's Na Hui-Kuo S		Spouse)				_				201,					878
1 and of Heal item		20a. Method of Disp	osition			20b. P	lace of Dispos	sition (Nar	ne of			Date C				own, State	070
Page nent o ant; if iry or		1 🛣 Burial 2 ☐ 4 🗌 Donation		3 ☐ Removal fron pecify)	n State		emetery, crem beck M	emor	Lal F	ark	Oct.	6,201	2 01	ney,	Mary	land	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Department of Health and Mentall Hygiene.  The man are stated other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur	neral Service	icensee	2		10	Name ar	d Addres	s of Facil	ity DeV	oj Fur 1 ye 877	neral	Home	е		
005 40		Noter	WX!	LMG		11 - J-11											
		23a. Part 1. Enter the shock, or hear Immediate Cause (I	rt failure. List o	nly one causé on e	ach line.					g, such as	cardiac (	or respiratory	arrest,			Approxima Interval Be Onset and	etween
hysician/ Medical	1	disease or condition resulting in death)				y Ar	tery D	iseas	se	-							
Examiner	,	On any antially list and			umon		,										
n #	ine	Sequentially list cor if any, leading to im cause. Enter Under	mediate rlying	40		consequ											
executed an and right	Examine	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):												-			
© 12 3 ©	_																
ath certificate be attending physicii for use as the bu	Physician/Medica	IE EEMALE.		U													
h cert tendin or use	ian/I	IF FEMALE: 23b. Was decedent in the past 12 n		23c. If yes, ou			ncy I death 3 🗆	Ectopic	pregnanc	y					te of delive		
e deat the at thed fo	ysic	1 Yes 2 Unknown	No	4 ∐ Preg 9 □ Unk		time of d	leath 5 L	Other (sp	pecify)				-	MO	enth	Day	Year
hat the ed by detac		Part II. Other signifi	icant conditio	ns contributing to	death bu	ıt not resi	ulting in the u	nderlying	cause giv	en in Parl	tl.	23e. Di	d tobacco	use conti	ribute to th	ne cause of	death?
uires t n sign ufd be	ed by											1	Yes :	2 🗷 No	3 Prob	bably 4	Unknown
iw req as bee 2 sho	plet											24a. W	as an			psy findings mpletion of	
The Is ate ha	Completed											pe	erformed?		death? 1 🗌 Yes		
ician: certific rector,	Be	25. Was case referre examiner?		Hospital:					Othe		ath (Checi	only one)					
r this eral di	e: To	1 L Yes 2 2 27. Manner of Death	☑ No n	28a. Date	of injury	у	ER/Outpatien 28b. Time of		DA Rock Injury	4 <b>X</b> I N		me 5 Re 28d. Describ				2	
nding ath. r: Afte ie fun	icat	1 X Natural 2 ☐ Accident	5 ☐ Pendin Investig	9	nth, Day,	Year)	injury	М	work?		_			,			
r Atte ter de irecto n by th	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could i determ	ined 28e. Place		ry - At ho (Specify)	me, farm, stre	et, factor	, office			28f. Location	n (Street a Town, Stat		er or Rural	Route Nurr	nber,
pital o		27 0 11	<b>9</b> 0	Di Talla					h 11 - 12	1.1						- 1	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician possible the funeral director, page 2 should be detached for use as the bigompletely filled in by the funeral director, page 2 should be detached for use as the bigompletely filled.	Medical	(Check 2	☐ Medical E	Physician: To the xaminer: On the ba Nurse Practitione	asis of ex	amination	and/or invest	gation, in	my opinio	n, death c	occurred at	the time, dat	te and plac	e, and due	e to the cau	use(s) and m	nanner stated
Vithin To the To	2	29b. Signature and t	title of certifier	C Ti	147	Desiron	ly knowledge,		. License	_	ate and pie	acc, and dec	_		d (Month, L		
2			Vian	Ganti	-				Ι	04116	52		Oct	ober	1, 2	2012	
		30. Name and addre								7	4-		2007	1.			
Char		Dr. Vinu					octors		ve, (	erma:	ntow	n, MD	2087	4			
Stat Registra		OC.		012 2	. rogistidi	, A.	de far	Les .									
				7000				-									

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland /				ind M	lental Hy	giene	112	22	902
			Registrar  1. Decedent's Name (First, Middle, Last)	Cer	tificate of D	eatn		2. Date of De	Reg. No. 4	112		
	Physicia		Rita Violet Spak						Day Der 28 2	Year	3. Time of [	
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of	Death	Septem	4c. County	_	6:00	P <sup>M</sup>
			17713 Shady Mill Road		Derw					gome	rv	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bird	hday)	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Bir	th	9. Birthp	lace (State or	Foreign
K	Director		201-14-5068 1 □ M 2 🖾 F 88	Yrs.	Months Days	nours	IVIIII.	Feb. 2	6, 1924	Pen1	nsylvar	nia
	nd <b>how</b> at		Usual Residence of Decedent           10a. State         10b. County         10c. City, Tow.	n or Loc	ation					1	0d. Inside City	v Limits
	laryla 3a-f s ified	Director	MD Montgomery	Derv	vood					1	1 🗆 Yes	-
	or 28	١	10e. Street and Number		10f. Zip Code		-		10g. Citizen of W	√hat Cour	itry?	
	s 23a	Funeral	17713 Shady Mill Road		2085	5		_ [	United	1 Sta	tes	
	death item	Fu	11. Marital Status 12. Was Decedent Ever in U.S.	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origi	n? (Spec	cify Yes or No-	14. Race	e - Americ	an Indian,	
36	after I", or xamir	l by	1 Never Married 2 Married 1 Yes 2 X No		☐ Yes 2 🛣 No		i deito i	iloan, oto.,		k, White, e		
응	ours atura cal E	Completed	fear of Dates.		ent's Usual Occupa					whit		
215	an "n Medi	mpl	(Specify only highest grade completed)	(Give h	ind of work done du NOT use retired)		of workir	g	16b. Kind of Bu	siness Inc	dustry	
2	withir giene er th			use	wife				Own Ho	ome		
D	filed tal Hy d oth event	To Be	17. Father's Name (First, Middle, Last)			18. Mother	's Name	(First, Middle,	Maiden Surname)	)		
<u>}</u>	uld be Men narke	۲	Anthony Slowik			Mari	e Za	astempa				
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at				g Address (Street ar							
	and deal em (				Bluhill sition (Name of	Road,						
Baitimore,	permit. Page 1: Department of I Important: If it any injury or of		1   ■ Burial 2 □ Cremation 3 □ Removal from State cemeter	ry, crem	atory or other place			ate - / 2 0 1 0	20c. Location -	-		
≣	nit. Partme oortar injur		21. Signature of Funeral Service Licensee	22	eaven Cen	s of Facility	De\	o/2012 j ol Fun	Silver S	prin e	g, Mar	yrand
ñ	Der Imp any		Custo: C Day (M01116)	10  Ga	Name and Address East Dee ithersbur	r Par	k Di 208	1ve 377				
			23a. Part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	ot ente	r the mode of dying	, such as ca	ardiac or	respiratory an	rest,		Approximate Interval Between	aan .
-	Physician/		Immediate Cause (Final disease or condition Myocardial Inf	arc	tion					М	Onset and De	
	Medical Examiner		resulting in death)  Due to (or as a consequence of									
		er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	. 6.						$\rightarrow$	_	
	pa tig	Examine	if any, leading to immediate  Due to (or as a consequence of cause (Disease or liniury)	)):								
	be executed sician and burial terms!	Exa	that initiated events c. Due to (or as a consequence of	of):		_						
20	ath certificate be executed attending physician and for use as the burial tension	dical	d									
00/0	tificat ng ph as th	Med	IF FEMALE:									
×	h cerl tendii or use	Physician/Me	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live Birth 2  Fetal death	3 🗆	Ectopic pregnancy				23d. Date	e of delive	ry	- 1
POX	e deat the at ned fo	ysic	1 ☐ Yes 2 🖾 No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 🗌	Other (specify)				Mon	th	Day Yea	ar
<u>.</u>	at the		Part II. Other significant conditions contributing to death but not resulting in	n the ur	derlying cause give	en in Part I.		23e Did to	bacco use contrib	bute to th	e cause of dea	ath2
, L	signe d be o	d by			, ,				Yes 2 □ No (			
ecords,	requ been shoul	lete						24a, Was			sy findings ava	
Š	ne law e has age 2	Completed						autop perfo	rmed? pr	rior to con eath?	npletion of cau	ise of
<u>.</u>	an: Ti tifical tor, pa		25. Was case referred to medical		26. Plac	ce of Death	(Check	1 Yes	2 K No. 1	☐ Yes	2 🔀 No	
NI C	nysici iis cer direc	일	examiner? 1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Ou	tpatient	Other				lence 6  Other	(Specify)		
5	ng Pł		27. Manner of Death 28a. Date of injury 28b. T  1   Natural 5 □ Pending (Month, Day, Year) ir	ime of ijury	28c. Injury a work?	at			ow injury occurred			
VISION	tendi death. tor: A the fu	iii iii	2 Accident Investigation		M 1 □ Y	′es 2□N	0		_			
200	l or At after of Direc	Certificate:	4 Homicide determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, stre	et, factory, office		2	8f. Location (S City or Tow	treet and Number n, State)	or Rural I	Route Number,	;
ב	spital hours neral d fillec	Medical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, c	death or	cured at the time, of	date and pla	ace, and	due to the cau	use(s) and manner	as stated	l.	
	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending pt completed filled in by the funeral director, page 2 should be detached for use as the funeral director, page 2 should be detached for use as the funeral director, page 2 should be detached for use as the funeral director, page 2 should be detached for use as the funeral director, page 2 should be detached for use as the funeral director.	Med	(Check 2 Medical Examiner: On the basis of examination and/or only one) 3 Certifying Nurse Practioner: To the best of my knowle	r investi	gation, in my opinion	, death occu	irred at t	ne time, date a	nd place, and due t	to the caus	se(s) and mann	er stated.
	P Market		29b. Signature and title of certifier		29c. License r	number			29d. Date signed	(Month, D	ay, Year)	
	-		/ Un John		D201	48			October	1,	2012	
			30. Name and address of person who completed cause of death (item 23a) (I		í	C a 4 +1	1	35	D 20077			
	Stat		Steven H. Dolinsky, M.D., 911 Russ 31. Date filed (Month, Day, Year)  32. Registrar's Signature	eTT	Avenue,	Gaith	erst	ourg, M	ע עטט//			
	Registra	_	31. Date filed (Month, Day, Year)  OCT 0 4 2012  31. Registrar's Signature	bau								

		Pleas	e Type or Pr								_	ole.	
		For State Registrar	State of M	1arylan		rtment tificate			nd Mental		20	12	3300
Dhysisis	-/	1. Decedent's Name (First, Middle, I	,			imouto	0, 0,		2. Date of				3. Time of Death
Physicia Medic	al			ausse	er				Sept	. 28	201		7:15 PM
Examin	er	4a. Facility Name (if not institution, g 3128 Gracefi		#302	2	4b. City, To		ocation of l. Spri			4c. County of <b>Mont</b> g		:y
Funeral		5. Social Security Number 6 5 7 7 - 1 0 - 3 3 5 6			ast birthday)	If Under 1		If Under 24 Hours	Min. (Mont)	f Birth	r) 9		ce (State or Foreign
Director		Usual Residence of Decedent	1 □ M 2 🗓 F	9	Yrs.				May	28,1			ginia
yland -f shov ed at	ctor	10a. State 10b. County MD Monto	omery	1	y, Town or Local lver S		ď					100	d. Inside City Limits
he Mar or 28a s notifi	Director	10e. Street and Number	Omer y		TAGT .	10f. Zip Co			_	100	Citizen of Wha	at Countr	1 Yes 2 X No
filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f show went, the Medical Examiner must be notified at	Funeral	3128 Gracefie	eld Road	#302			904			l rog.	USA	at Country	, .
r death		11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent Armed Forces	-		/as Deceden Yes, specify	nt of Hisp Cuban,	oanic Origin Mexican, F	? (Specify Yes or Puerto Rican, etc.	No-	14. Race - Black,	American White, etc	
ırs afte ıral", o	ed by	3 X Widowed 4 □ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates.	<b>&gt;</b> No	1	☐ Yes 2 🛚	X No	Specify:			Specify:	Whit	ce
72 hou n "natu ledica	Completed	15. Decedent's (Specify only highest			(Give k	ent's Usual C	done dui	ion ring most of	f working	16b	. Kind of Busir		,
within giene.		Elementary/Secondary (0-12) 12	College (1-4 or	5+)		NOT use re					Insur	ance	9
d be filed fental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, Las John Francis		n	-				Name (First, Mice)			Ca	vanagh
permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturary injury or other traumatic event, the Medical once.		19a. Informant's Name/Relationship Mary Alice Co		er					r Rural Route Nu Falls C				de) 0 4 3
ge 1 and nt of Hea t: <b>If item</b> or othe		20a. Method of Disposition 1   M Burial 2 □ Cremation 3		20b. P	lace of Disposemetery, cremeratery, cremerat	sition (Name of	of er place)		Date Date		Location - Cit	-	
mit. Pa partmen cortant injury		4 Donation 5 Other (Special Signature of Funeral Service Lice		rai					2012 Fairfa		airfa: moria	<u> </u>	
Der m any		Febro Balli	- CC0504	/	H	ome,9	9902	2 Bra	ddock	Rd.,	Fairf	ax,	A 22032
Physician/ Medical		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lir	re t	o thr		of dying,	such as car	rdiac or respirato	y arrest,		lr	pproximate nterval Between Inset and Death
Examiner			Due to (or as		ence of):  Impa	irmen	ı <del>t</del>						
n äa	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as			II men						7.	4
decuted and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequ	ence of):							+	
e be ey ysician ie buriż	ica		<b>d</b>										
ertificat ling ph	Me	IF FEMALE:	O2a If you guttoome	of neadons									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 XNo 9 ☐ Unknown	23c. If yes, outcome  1  Live Birth 4  Pregnant a	2 Feta	Ideath 3	Ectopic preg Other (speci				_	23d. Date o Month	f delivery Da	
that the	by Pi	Part II. Other significant conditions		out not resu	ulting in the ur	derlying cau	use giver	n in Part I.	23e. [	oid tobacco	use contribu	te to the	cause of death?
equires een sig nould b		Osteoporosis							_   1	☐ Yes	2 <b>X</b> No 3 [	Probab	oly 4 🗆 Unknown
has be	Completed	Coronary Art		ase					— I a	Vas an lutopsy erformed?	prio	r to comp	findings available letion of cause of
an: The tificate tor, pa	ا به	Hypertensior 25. Was case referred to medical	<u>1</u>				26. Plac	e of Death (	1 🗆 Check only one)	res 2 💢	No 1	Yes 2	□ No
hysicia his cer al direc	19 B	examiner? 1  Yes 2  No			ER/Outpatient		Other		ng Home 5 🔀 F	Residence	6 Other (S	Specify)	
ding P th. After t funera	gate:	27. Manner of Death  1 X Natural 5 Pending	28a. Date of inju (Month, Da		28b. Time of injury	28c.	. Injury a work?	t es 2 □ No		be how inj	ury occurred		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director,	Certificate:	2 ☐ Accident Investigat 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 280 Place of Ini					-	28f. Location	on (Street a Town, Sta	and Number of te)	r Rural Ro	oute Number,
lospital 4 hours uneral ely fillec	Medical	29a. Certifier 1 X Certifying Pl	nysician: To the best of	my knowle	edge, death or	ocurred at the	e time, o	date and pla	ace, and due to the	ne cause(s)	and manner a	as stated.	(a) and
the Fithin 24 the Fithin 24 the Fithin 24 the Fithin 24 the Fithin 24 the Fithin 24 the Fithin 24 the Fithin 24 the Fithin 34 th		(Check 2 ☐ Medical Exa only one) 3 ☐ Certifying No 29b. Signature and title of certifier	miner: On the basis of e urse Practitioner: To th	ne best of m	y knowledge,	death occurre	opinion, ed at the icense n	time, date a	ind place, and due	to the cau	se(s) and manr	ner as stat	red.
¥ ¾ ¥ 8		Lach Mal	en	> 1	LEXIO				6	29d. L	Date signed (M) $10/3/$		
		30. Name and address of person who	completed cause of c				r 1	1101			1-101	-01	

State Registrar

31. Date filed (Month, Day, Year) OCT 04 2012

Dr. Rachelle Alexion, MD, 3110 Gracefield Rd., Silver Spring, MD 20904 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 33911 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Roger Dale Semerad October 2012 3:25 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sunrise at Fox Hill Montgomery <u>Bethesda</u> Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Director 108-32-8761 1 **№** M 2 🗆 F Sept. 9, 1940 Usual Residence of Decedent 72 New York 10a. State 10b. County ?? Is merkad other then "netural", or items 23a or 28e-f sho treumatic event, the Medical Examiner must be notified at the Maryland 10c. City, Town or Location 10d. Inside City Limits Director D.C. None 1 Yes 2 No Washington, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4033 Mansion Drive, N.W. 20007 USA within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 🖾 Yes 2 🗌 No Black, White, etc. 1 Never Married 2 K Married 2 21215-0036 1362 8861 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: and Mental Hygiene. Is merkad other then "netural", Completed Specify: White 3 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Public Policy Executive Federal & Corporate Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) parmit. Page 1 and 2 should be file Dapartment of Health and Mental Importent: If Itam 27 is merked eny injury or other treumatic ever 2008. ည Ralph Donald Semerad Marjorie Burdekin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4033 Mansion Drive, N.W. Washington, D.C. 20007 Cathryn Semerad/Spouse Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Metropolitan
Crematory 1 Burial 2 K Cremation 3 Removal from State October 4 Donation 5 Other (Specify) 2012 Alexandria, 21. Signature of Funeral Service 22. Name and Address of Facility DeVol Funeral Home M00215 2222 Wisconsin Ave. N.W. Washington, <u>200</u>07 D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Urinary Tract Infection Days Medical resulting in death) Due to (or as a consequence of): Examiner Sepsis Days Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying n and Cause (Disease or injury that initiated events Hospital or Attending Physician: The lew requires that the death certificate ba axecuted Paraplegia Years Due to (or as a consequence of) burialresulting in death) Last attending physiclen Physician/Medical Multiple Sclerosis Years Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ò in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year the detached 9 Unknown 9 Unknown P.0. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| Division of Vital Records, bean signated Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy this certificate director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours effer death.
To the Funerel Director: Affer completely filled in by the fun X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of confif 29c. License number 29d. Date signed (Month. Day, Year) October 15, 2012

Registrar

State

30. Name and address of g

Schiffman,

31. Date filed (Month, Bay, Year) 0CT 16 2012

9613 Bellevue Drive,

20814

Bethesda, Maryland

erson who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

M.D.

			Plea	se Type or I								-			ible.		
		For State Registrar		State of	iviary	/iana /			nt of F te of E		and IV	/lental Hy	/gien Reg. N	20	12	3390	15
Dhusisi	an /	Decedent's Nam	e (First, Middle	Last)								2. Date of D	eath		Voor	3. Time of Death	<u> </u>
Physici Medi	cal			ricia G. U		ς						Septer	T			11:30 A	M
Exami	ner	7841 Ric		give street and numb d	er)				y, Town, or Hanov	Location o	of Death		4	c. County Anne	of Death  Aru	ndel	
Funeral		5. Social Security N	umber	6. Sex 7	. Age (In	yrs. last l	birthday)	If Und	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi			9. Birthp	place (State or Forei	gn
Director		212-28-72 Usual Residence		1 □ M 2 🔀 F	80	0	Yrs.					09/29	/193	31	Ma	ryland	
yland f shov ed at	tor	10a. State	10b. County		100	c. City, To	own or Lo	cation							1	0d. Inside City Limi	
r 28a- notifie	Direc	MD 10e. Street and Nur		Arundel	I	Hano	ver	10f Z	ip Code				100 (	Citizen of W	(hat Coun	1 🗆 Yes 2 🔀	No
with the s 23a c ust be	Funeral Director	7841 Rid		l				'02	210	76				nited		-	
death ritems nerm		11. Marital Status		12. Was Deced	es?	in U.S.	13. \	Was Dece f Yes, spe			gin? (Spe	ecify Yes or No Rican, etc.)	-		- Americ	an Indian,	
ours after tural", or al Exami	d by	1 ☐ Never Marr 3 ☐ Widowed	-11	ied 1 \(\sum \) Yes 2 If Yes, Give Year or Date						Specify:				Specify:	Whi		
2 hour "natur	Completed	(Spe		t's Education st grade completed)		1			ual Occupa	ation uring most	t of work	ina	16b.	Kind of Bu	siness/Ind	dustry	
ithin 7 ene.	Com	Elementary/Second 12		College (1-4	or 5+)		life. D	O NOT us	se retired) rati			3	Fe	edera <sup>*</sup>	l Gov	ernment	
filed wall Hygi	Be	17. Father's Name (	First, Middle, L	ast)			2 83011	LILLO	1001		er's Nam	e (First, Middle				CITATION	
yldi uld be Menta narkec	12	Harry Ha										Amer					
2 shoulth and 27 is not traum		19a. Informant's Na Albert U				- 1						al Route Numb er, MD			ate, Zip C	Code)	
1 and of Heal item		20a. Method of Disp	position			0b. Place	of Dispo	sition (Na				Date		Location -	City or To	wn, State	
mit. Page 1 partment of portant: If it y injury or o			☐ Cremation 5 ☐ Other (S	3 ☐ Removal from S pecify)	tate 1		. Nat	tiona	al Cer	n.		1/2012		timo			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	neral Service Li	censee	4											y FH Inc	•
TEN SERVICE	г			complications mat ca		death. D					-			ICC C.	LLY,	MD 21043 Approximate	
Physician/		Immediate Cause (	(Final	nly one cause on each		ascul	Lar A	ccid	.ent							Interval Between Onset and Death	
Medical Examiner		resulting in death)	71	Due to (or	r as a con	nsequenc											
	ner	Sequentially list co	nmediate	b. Hyper Due to (or			e of):								$\rightarrow$		
e executed cian and vurial-transit	Examiner	cause. Enter Unde Cause (Disease or that initiated event	injury s	С.													
oe exec ician a burial-		resulting in death)	Last	Due to (or	r as a cor	nsequenc	ce of):										
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the b	cian/Medical			d				-									
th certi	ian/N	IF FEMALE: 23b. Was decedent in the past 12		23c. If yes, outco	rth 2 🗌	Fetal de	ath 3			у			(9)	23d. Date		*	
the at	Physic	1  Yes 2 Unknown	X No	4 ☐ Pregna 9 ☐ Unkno		e of deat	h 5∟	Other (s	specify)		-			Mor	itn	Day Year	
that the ned by	by Pr	Part II. Other signif	ficant conditio	ns contributing to dea	ath but no	ot resultin	ıg in the u	ınderlying	cause giv	en in Part l	l.	23e. Did	tobacco	use contri	bute to th	e cause of death?	
requires been sig												1	Yes !	<u>^</u>		pably 4 🗆 Unknow	
law re has be ge 2 sh	Completed			·								24a. Was auto perf	s an opsy formed?	р		psy findings available expletion of cause o	
vital neconysician: The lavinis certificate has	Be Co	25. Was case refern	ed to medical						26. Pla	ice of Deat	th (Checi	1 🗌 Yes			☐ Yes	2 🗆 No	
hysicia hysicia nis cer	To B		<b>₹</b> No	Hospital: 1 ☐ In	patient	2 🗆 ER/	'Outpatier	nt 3 🗆 🗓	Othe	r.		me 5 <b>K</b> Res	idence	6 🗌 Other	r (Specify)		
ding Pl h. After tl funera	ate:	27. Manner of Deatl	5 🗌 Pendin	<b>9</b>	injury , <i>Day,</i> Yea	<i>ar</i> ) 28t	o. Time of injury	М	28c. Injury work			28d. Describe	how inju	iry occurre	d		
Attencer death	Certificate:	2  Accident 3  Suicide 4  Homicide	Investig 6  Could r determi	not be 28e. Place o	f Injury - /	At home,	farm, stre			res Z 🗆	NO				r or Rural	Route Number,	
ital or urs after ral Dir				building	, etc. (Sp	pecity)						City or To	wn, Stat	e)			
Hosp 24 hou Fune etely fi	Medical	(Check 2	Medical E	Physician: To the best caminer: On the basis	of examir	nation and	d/or invest	tigation, ir	my opinio	n, death oc	curred at	the time, date	and plac	e, and due	to the cau	ise(s) and manner st	ated.
To the within To the compl	Σ	only one) 3 29b. Signature and		Nurse Practitioner:	o trie des	st of frily KI	iowiedge,	/	curred at tr		e and pla	ace, and due to		ate signed			
		• /	//						D1850	08			9/	27/20	12		
14		_		ho completed cause						11140	106	Clar B	1122	O NAT	21/	161	
Sta		31. Date filed (Mont	h, Day, Year)	Wu 1600	istrar's S					urte	100	Gren B	uLIL	Le, M	<i>J</i> <u>Z</u> 1(	NOT.	
Registr	ar		OCT 0 1	2012 🞉	un	1 6	7.	ark	_								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33906 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death September 29, 2012 Physician/ Volkman, Jr. August 5:21 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3701 International Drive, Apt. 112 Montgomery Silver Spring 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days 577-09-6424 Hours (Month, Day, Year) Director 1 **₹** M 2 □ F 100 Jan. 31, 1912 Washington, DC ed other than "netural", or items 23e or 28e-f show event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location the Maryland Director 10d. Inside City Limits MD Montgomery Silver Spring 1 Yes 2 K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral filed within 72 hours after death with 3701 International Drive, Apt. 112 20906 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ♣ No Black, White, etc ò 1 Never Married 2 Married Maryland 21215-0036 Specify White 1 ☐ Yes 2 ☐ No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Ith end Mental Hygien 27 is marked other the r traumatic event, the Attorney Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fil f Health end Mental item 27 is marked ပ္ William August Volkman Ada Lillian Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary V. Niemiec/Daughter 10508 Parkwood Drive, Kensington, MD 20895 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20a. Method of Disposition Page 1 Department of H Important: If ite eny injury or ot once. 20c. Location - City or Town, State Oct. 1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2012 Alexandria, VA 21. Signature of Funeral Service Licensee Prancis J. Collins Funeral Home Inc. 500 University Blvd. W, Silver Spring Part 1. Inter the disease, or complications that caused the deal on the note of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Interval Between Immediate Cause (Final Onset and Death Physician/ Cancer of Prostate disease or condition resulting in death) 6 mos Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ie attending physicien and ed for use as the buriet tegs! Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, Diabetes Mellitus (Type II), Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown this certificate has been si ral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Chronic Kidney Disease, Atherosclerotic Peripheral 24a, Was an autopsy performed? Yes 2 No Vascular Disease 1 🗌 Yes 2 🔲 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☒ No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ₺ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work≀ 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 06-2011

State

George F.

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Sengstack,

03 2012

Year)

D12121

3929 Ferrara Drive, Slver Spring, MD 20906

October 1, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33907 Certificate of Death 2. Date of Death 3. Time of Death Physician/ Sept. 28 Day 2012 Year 12:29 ам Margaret Anna Francisca Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 212-68-0575 Director 1 M 2 XF 84 Usual Residence of Decedent May 28, 1928 India 10a. State 10c. City, Town or Location with the Maryland ir then "neture!", or items 23e or 28e-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 12426 Littleton Street 20906 USA within 72 hours efter death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give δ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify.Asian Indian 1 ☐ Yes 2 ☑ No Specify: Completed 3 Wildowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) parmit. Page 1 and 2 should ba filed wit Department of Health and Mental Hygler Important: If Item 27 is merked other teny injury or other treumetic event, Its 20059. Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert T. Fernandes Theodolinda Maria DeSousa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Ide/Daughter 13620 Middlevale Lane, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Metropolitan Crematory 1 ☐ Burial 🏂 Cremation 3 ☐ Removal from State Oct. 2, 2012 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ onthresidentic heart disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events Due to (or as a consequence of) attending physicien and for use as the burial-trensit To the Hospital or Attanding Physicien: The law requires that tha death certificate be executed within 24 hours effer deeth.

To the Funerel Director: After this certificate has been signed by the attending physicien and compietely filled in by the funerel director, page 2 should be detached for use as the burigi-trensli resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 WNo
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) 4 Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autoosy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 □ No မ 1 ☐ Inpatient 2 ☑ R/Dutpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 55. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 detrifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

Ł

7600 Carroll Avenue, Takoma Park, MD 20912

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kilole Kanno, MD

31. Date filed (Month, Day, Year) OCT 03

67613

09-28-12

12-05522 **Durward Wolfe**  Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 33908

	1- For State Registrar		Certific	ate of	Death				Reg. No.						
Physician/ Medical Examiner	Decedent's Name (First, Midd Durward Wolfe	· · · · ·						Date of De Month July 23, 1	Day	Year		3. Time of Death 2145 hrs			
	4a. Facility Name (if not institution 259 Burns Crossing F			41	o. City, Town, o Odenton	or Location	of Death			County of nne Aru					
Funeral Director	5. Social Security Number 411-48-2628	6. Sex 7. Age	e (In yrs. last bir	thday) Yrs,	If Under 1 Ye Months Da			8. Date of E			Foreign	nplace (State or ntry) TN			
w any	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town		n							10d. Inside City Limits  1 Yes 2 No			
Maryland 28a-f show any 1 at once.	MD Anne 10e. Street and Number	Arundel	Severn	Ī	10f. Zip Code			- 1	10g. Citiz	en of Vyha					
h the N 3a or setifie	259 Burns Cros				21144					USA	A				
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.  Int. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status  1 Never Married 2 M  3 Widowed 4 X Div	12. Was Decedent Armed Forces?  1 Yes 2 worced If Yes, Give Year	Ever in U.S.	If Yes	Decedent of H s, specify Cuba res 2 X N	n, Mexican	, Puerto Rio			14. Race - White, Specify.W	etc.	an Indian, Black,			
ntural namin	15. Decedent's Education (Spe	or Dates:		Decedent's	s Usual Occupa	ation (Give	kind of worl			ind of Bus					
5-0036 ed within 72 hours aft tygiene. other than "natural" the Medical Examine Completed by	Elementary/Secondary (0-12) 5	College (1-4 or 5	+)	auring mos	st of working lif	e. DO NOT	use retired	)	Sp	ring	Gro	ove Hosp.			
Street and Number of Lloyd C. Wolfe  17. Father's Name (First, Middle, Last)  Lloyd C. Wolfe  19a. Informant's Name/Relationship (Type, Print)  Lloyd C. Wolfe (Son)  19b. Mailing Address (Street and Number of Lloyd C. Wolfe (Son)									Name (First, Middle, Maiden Surname)						
AD 21 2 should b and Me 27 is maximatic ev	Aid  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)  19. Mailing Address (Street and Number or Rural Roll of Linguistics o														
Baltimore, Nermit. Pages I and Department of Healt Important: If item injury or other tran	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory  9/30/2										Date 20c. Location - City or Town, State				
Itim ii. Pagartment ortant	4 Donation 5 Other Signature of Funeral Service	desty Funeral Home													
Depri Inju	3. Ch														
Physician IMedical Examiner	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Atheros clerotic Cardiovas cular Disease.														
- Adminion	or condition resulting in death)  Sequentially list conditions,	Due to (or as a conse	quence of):												
ted nnsit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	C													
60, e be executed ysician and burial - transit ledical Exa	events resulting in death) Last	Due to (or es a conse	quence of):												
ie be ex ysician burial -	UNPENDED	AMENDED													
ox 6876 ath certificat attending ph or use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unit	23c. If yes, outcom  1 Live birth  4 Pregnant at t		Feta	I death 3	Ectopic	pregnancy		- 11	Date of d Month	elivery Da	y Year			
, P.O. Be res that the de signed by the be detached for d	Part II. Other significant condit		but not resulting	g in the und	derlying cause	given in Pa	nrt I.	l				e cause of death?			
Division of Vital Records, lat or Attending Physician: The law requires rs after death.  The law requires the law requires the law been signed in by the fineral director, page 2 should be retification: To Be Completed							_		psy ormed?	pri de	or to cor ath?	psy findings available mpletion of cause of			
Vital Rec ysician: The lhis certificate director, page	25. Was case referred to medica	1			26.Plac	e of Death	(Check only		2 No	1 •	✓ Yes	2 No			
f Vital Physician r this certi al director	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatien	t 2 ER/O	utpatient		Other <sub>4</sub>	Nursing H		Residen	ce 6 🗸	Other: \$	Scene			
on of \ ending Ph ath. vr. After tl he funeral of	27. Manner of Death  1 Natural 5 Pend		y 28b. ar)	Time of Inju		ry at Work		d. Describe	how injur	y occurred	_				
Division of oppiration of oppiration of Attending hours after death, nerral Director: Aft y filled in by the fune Certification:	3 Suicide 6 Coul	28e. Place of Injuined (Specify)	ıry - At home, fa	rm, street,	factory, office	building, et	c. 281	f. Location or Town,		d Number	or Rura	l Route Number, City			
Div To the Hospital or within 24 hours afte To the Funeral Div completely filled in	29a. Certifier (Check only 1 CertifyIng Pl	hysician: To the best of my miner:On the basis of exam and manner stated.													
A S H S O	29b. Signature and title of certifie				29c. Licen				29d. Da	ate signed	(Montl	h, Day, Year)			
	30. Name and address of person	who completed cause of de	ath (Item 23a)		0.C.	M.E.			July 2	24, 201	2				
15	Pamela E. Southall, M	ID Assistant Medic	al Examine	900 \	V. Baltimoı	e Street	, Baltimo	re, MD 2	21223						
State Registrar															

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of Maryland / Dep	partment of Health and Mertificate of Death	lental Hygiene	2012 33909			
	Physicia	an/	1. Decedent's Name (First, Middle, Last)		2. Date of Death  Month  Day	3. Time of Death			
- 14	Medi Examii		Joanna P. Walker  4a. Facility Name (if not institution, give street and number)  WMHS Hospital	4b. City, Town, or Location of Death Cumberland	4c. Cc	$\frac{2012}{2200}$ M ounty of Death Alleg.			
	Funeral Director		5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  1  M 2 M F  79 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 2 - 17 - 33	9. Birthplace (State or Foreign Country)  MD			
	Maryland 28a-f shov otified at	irector				10d. Inside City Limits 1    Yes 2 □ No			
	with the s 23a or ust be n	eral D	10e. Street and Number 1380 Ludwick	10f. Zip Code 26726	10g. Citizer US	n of What Country?			
9800	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 ☐ Yes 2X No  If Yes, Give Year or Dates.	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 ☑ No Specify:	cify Yes or No- 14.	Black, White, etc.			
21215-0036	2 should be filed within 72 hc h and Mental Hygiene. 7 is marked other than "na traumatic event, the Medic			dent's Usual Occupation kind of work done during most of workin ONOT use retired) OMEMBRES	g 16b. Kind Hom	of Business/Industry			
Maryland	ild be filed Mental Hy narked ott atic even	To Be	17. Father's Name (First, Middle, Last) Ralph Mckenzie	<i>(First, Middle, Maiden Surr</i> <b>Mae Colema</b>	e Coleman				
	and 2 shou Health and tem 27 is n		Nancy Whitehurst Daugh 24	ng Address (Street and Number or Rural Bright Cherry	Route Number, City or Tov Ct. Martin	wn, State, Zip Code) 25403 sburg, WV			
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other once.		20a. Method of Disposition  1 ▼ Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition State Potomac	matory or other place) Mem. Gardens 1	0-8-12Keys				
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licensee  2:  Williams H. Fredlo-Bar	edlock Fun edmont, WV					
	Physician Medical	7	23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	er the mode of dying, such as cardiac or Injury Subdura		Approximate Interval Between Onset and Death			
	Examiner	je.	Sequentially list conditions, b.	<i>D</i> : = '		7			
	ecuted and rtransit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):			7			
	ificate be executed ig physician and as the burial-transit		d			19413			
). Box 68	res that the death certifica signed by the attending pl d be detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3	Ectopic pregnancy Other (specify)	23d	l. Date of delivery Month Day Year			
rds, P.O.	requires that been signed t should be det	þ	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.		contribute to the cause of death?			
Il Reco	nysician: The law rais certificate has book director, page 2 sk	e Completed	25. Was case referred to medical	OS Place of Parth Object	autopsy performed? 1 \sum Yes 2 \sum No	4b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No			
f Vita	Physicia this cert al direct	To Be	examiner? 11 Yes 2 \( \text{No} \) No Hospital: Inpatient 2 \( \text{ER/Outpatien} \)		ne 5 Residence 6 (	Other (Specify)			
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  With Euneral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for	Certificate:	27. Manner of Death  1 Natural 5 Pending Investigation 3 Suicide 4 Homicide  28a. Date of injury (Month, Day, Year)  29a. Date of injury (Month, Day, Year)	work?  M 1 2 Yes 2 7 No		Imber or Rural Route Number, w			
Ω	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investi	tigation, in my opinion, death occurred at the	ne time date and place and	nanner as stated.			
	To the within To the compl	Σ	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, 29b. Signature and the of certifier	death occurred at the time, date and place 29c. License number		nd manner as stated. gned (Month, Day, Year)			
			30. Name and address of persony ho completed cause of death (Item 23a) (Type, F	194124 Print)	10	0/4/12			
	Stat	၁	Tamay KErTING  31. Date filed (Month, Day, Year)  A2. Registrar's Signature	12500 Willasta	X Rd. ComBi	ESLAND/19 2/501			
	Registra	_	OCT - 9 2012	led					

DHMH 17 Rev 06-2011

		1- For State Registrar		Cei	rtificate o	f Death		<b>, ,</b>	Reg. No.	112	33911
Physicia Medical Exami		Decedent's Name (First, Midd Morris Duane V						2. Date of De Month October			3. Time of Death 1910 hrs
		4a. Facility Name (if not institution 1781 Blocker Road	on, give street and number)	)		4b. City, Town	n, or Location o		4c. County Garrett	of Death	
Funeral Director		5. Social Security Number 218–64–9304	6. Sex 7. Ag	e (In yrs. I	ast birthday) 58 Yr		Year If Under Days Hours	1 Min	9, 1954	Foreign	
от яну		Usual Residence of Decedent  10a. State 10b. County  MD Garre			Town or Loca	ition	<u> </u>				10d. Inside City Limits  1 Yes 2 X No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number		FLO	scourg	10f. Zip Co	de		10g. Citizen of W		
ith the Maryland 23a or 28a-f sho notified at once.		1781 Blocher F				215			USA		
fler death w	/ Funeral	11. Marital Status  1 Never Married 2 X M  3 Widowed 4 Div	1 Yes 2			Yes, specify C		jin? ( Specify Yes or N Puerto Rican, etc.)		te, etc.	an Indian, Black,
2 hours at "natural	ted by	15. Decedent's Education (Spe	ecify only highest grade con				upation (Give I	kind of work done use retired)	16b. Kind of B	usiness/Ind	dustry
5-0036 ed within 72 tygiene. other than '	Completed	Elementary/Secondary (0-12)		5+)	Heavy	Equipm	ent Ope		Const		lon
21215-0036 Juld be filed within 72 hours al Mental Hygiene. marked other than "natural c event, the Medical Examin	Be Co	17. Father's Name (First, Middle Clarence Warn)						s Name (First, Middle ie Warnick		∌)	
MD 21: nd 2 should buth and Mer in 27 is mar		19a. Informant's Name/Relations Vicky Lynn Warr				•		ber or Rural Route No Frostburg			Zip Code)
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other tinjury or other traumatic event, the Med		20a. Method of Disposition  1 Burial 2 X Cremation  4 Donation 5 Other S	_	ate (	Place of Dispo crematory or o untry S	ther place)		Date 7 Oct. 4,	20c. Location 2012 Dav	•	
Baltil permit. Departm Importa		21. Signature of Funeral Service	Licensee	J				Newman F Grantsvill		omes, 1536	P.A.
Physician Medical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.			the mode of dy	ring, such as ca	ardiac or respiratory a	rrest, shock, or he	art	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Contact Gunsho  Due to (or as a conse						<del></del>		Deau
	ner	Sequentially list conditions, if any, leading to immediate nause. Enter Underlying Gauss	b	equence of	f):				-		
ed nsit	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	equence of	f):						
760, icate be executed physician and the burial - transit	Medical	UNPENDED	d AMENDED								
cath certificate be attending physic for use as the bur	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcorn  1 Live birth  Pregnant at		2 F6	etal death	3 Ectopic	pregnancy	23d. Date of Month	f delivery Da	y Year
Box 68 he death certifi 7 the attending hed for use as	Physic		known 9 Unknown		3 0	ther (Specify)		222 Did	420-22-12-2	aile de la de	a server of death?
s, P.O. Box nires that the de- n signed by the a	Ď	Part II. Other significant condit	ions contributing to death	n but not re	esulting in the	underlying cau	ise given in Pa	1Y		Probat	bly 4 Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Completed					***		perf	opsy formed?		psy findings available mpletion of cause of
Vital Rec hysician: The this certificate	o Be (	25. Was case referred to medica examiner?  1 ✓ Yes 2 No	Hospital: 1 Inpatie	ent 2	ER/Outpatien		Other	Check only one)  Nursing Home 5	Residence 6	✓ Other: {	Scene
on of \center cending Phy agh.  or: After the funeral center cent	<b>-</b>	27. Manner of Death 1 Natural 5 Pend	28a. Date of Inju	ıry	28b. Time of FOUND: 1930 hrs		Injury at Work	28d. Describe	how injury occur		
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Cou	stigation Oct 2, 2012 28e. Place of In (Specify) res			et, factory, offi	ce building, etc	or Town,			Route Number, City
the Hos hin 24 ho the Fun npletely	Medical (		hysician: To the best of my nminer:On the basis of exam								
To viii	Me	29b. Signature and title of certifie	er and manner stated.				ense number		29d. Date sign		h, Day, Year)
		30. Name and address of person	,						October 3,		
	() ate	Patricia Aronica-Polla 31. Date filed (Month, Day Year)	k MD. Assistant M				altimore Str	eet, Baltimore, N	/ID 21223		17
St. Regist	rar	nct -	5 2012 /2	4-4	A. 100	wed	•				

12-07161

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lenda Fay Weicht	State of Maryland / Department of Health at 1-For State Certificate of Death Registrar	Reg. No.	2012 3391
Physician/	1. Decedent's Name (First, Middle, Last) Glenda F. Weicht	2. Date of Death Month Day September 22, 2012	Year 1350 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, 310 Paladium Court Owings M	or Location of Death 4c. Cour	nty of Death more County
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye	ear If Under 24Hrs. 8. Date of Birth (MM/DD/Y) ays Hours Min. 03/06/1952	9. Birthplace (State or Foreign MD Country)
Maryland 288-f show any d at once. ector	Usual Residence of Decedent  10a. State MD  10b. County Baltimore  10c. City, Town or Location	Owings Mills	10d. Inside City Limits 1 X Yes 2 No
eath with the Maryland items 23a or 28a-f sho ast be notified at once meral Director	10f. Zip Code 3 10 Paladium Ct. Unit 301		f What Country? USA
ter de	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced or Dates:  Armed Forces? 1 Yes, specify Cub	nan, Mexican, Puerto Rican, etc.) Who specify: Specify:	Race - American Indian, Black, White, etc. White
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin To Be Completed by	Elementary/Spgondary (0-12)  College (1-4 or 5+)  during most of working in Adm	ife DO NOT use retired)	State Of Maryland
21215-0036 uld be filed within 7 Mental Hygiene. marked other than ic event, the Medica FO Be Compil	17. Father's Name (First, Middle, Last) Joseph Weicht	18.Mother's Name (First, Middle, Maiden Suma Bernice Faye He	
MD 21 nd 2 should alth and Me an 27 is ma aumatic ev		reet and Number or Rural Route Number City of mit Ave., Baltimore, ND 21237	tion - City or Town, State
Baltimore, permit. Pages 1 an Department of Hea Important: If itee	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of crematory of other place)  4 Donation 5 Other Specify:	10/6/2012	Swanton, MD
Balt permit. Depart Impor injury	h ( tredt)	ck Funeral Home, P.A. 710 Church Stre	
Physician Medical Examiner	23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dyir failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		Between Unset and
0,  be executed sician and bunial - transit edical Examiner	Sequentially list conditions b.		
50, te be executed ysician and burial - transit	d.  AMENDED 23a,27,per me,g932 10	-24-12 sm	
ox 6876 auth certificate attending phy for use as the i		3 Ectopic pregnancy Mont	ate of delivery hth Day Year
P.O. B ss that the digned by the e detached:		Jo giron in the art in	contribute to the cause of death?  3 Probably 4 V Unknown
Division of Vital Records, tal or Attending Physician: The law requires rs after death.  a) Director: After this certificate has been sighed in by the funeral director, page 2 should be artification: To Be Completed		24a. Was an autopsy performed?  1  Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 ✓ Yes 2 No
ital Recicion: The scertificate recetor, page	25. Was case referred to medical examiner?   Hospital: 4   Inpatient 3   EB/Outpatient 3   DOA	ace of Death (Check only one)  Other Nursing Home 5 Residence	6 ✓ Other: Scene
nn of Vi ading Physi th. : After this e funeral dir	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. I	Injury at Work? 28d. Describe how injury or Yes 2 No	ccurred
Division C  To the Bospital or Attending within 24 hours after death.  To the Funeral Director: Al completely filled in by the funeral Centification	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office (Specify)	ce building, etc. 28f. Location (Street and North or Town, State)	lumber or Rural Route Number, City
To the Hosp within 24 hos To the Func completely fi	(Check only one)  2 Certifying Physician: To the best of my knowledge, death occurred at the time one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.	nion, death occurred at the time, date and place, a	and due to the cause(s)
	) M. 1		e signed (Month, Day, Year)  nber 23, 2012
2	30. Name and address of person who completed cause of death (Item 23a)  Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore S	Street, Baltimore, MD 21223	
Stat Registra			

DHMH 17 Rev 1/2001 OCME 2006

**ÖRIGINAL** 

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012

Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rubin Melvin Wimbish October 2012 Medical 10:54 p<sup>M</sup> 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince Georges Funeral Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 10-26-1941 Months Hours 577-52-0301 Director 1 XM 2 🗆 F 70 Washington, DC Usual Residence of Decedent ian "natural", or items 23a or 28a-f show Medical Examiner must be notified at 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No P.G. Capitol Heights 10e. Street and Number 10g. Citizen of What Country? Funeral 7007 Valley Park Road 20743 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married ģ 1 ☐ Yes X☐ No Specify: 3 Widowed 4 Divorced Specify: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Second 12th ndary (0-12) College (1-4 or 5+) the Self-Employed Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked Wimbish **Eppie** Lydia Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlice Wimbish - Wife Page 1 and 2 7007 Valley Park Road, Capitol Heights, Md. 20743 Important: If iten any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Harmony Memorial Pk | 10-13-2012 | Landover, Maryland 22. Name and Address of Facility Ronald Taylor, II Funeral Home Signatu Funeral Service Licens 10583 Middleport Lane, White Plains, Md. 20695 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final atal Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). death certificate be executed Cause (Disease or injury that initiated events burial-tran resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Pregnant at time of death Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital within 24 hours a To the Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 10-4-12 San se of death (Item 23a) (Type, Print) CHEVERLY MD. 20785 32/Registrar's Signature State

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 9/30/2012 5:57 P M Van Α. Wente Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 5919 Gloster Road Montgomery Bethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral (Month, Day, Year) Director 1 KM 2 LF 488-20-9462 87 and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Montgomery Bet<u>hesda</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5919 Gloster Rd 20816 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ð Maryland 21215-0036 1 ☐ Yes 2 📆 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates. Korean White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygien Important: If item 27 is marked other than injury or other traumatic. 4+ Engineer Consulting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward H. Wente Pauline Barham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Wente / Wife 5919 Gloster Road Bethesda, MD 20816 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🛣 Cremation 3 🗀 Removal from State 10/03/2012 4 Donation 5 Other (Specify) National Crematory Falls Church, Va Signature of Funeral Service 22. Name and Address of Facility Joseph Gawler's Sons ul. M00063 5130 Wisconsin Ave NW Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mesothelioma Physician/ disease or condition resulting in death) Months Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnetagent attending physician and I for use as the bured transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death
9 Unknown Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 A No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 X No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death or of at the time, date and place, and due to the cause(s) and manner as state 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0023600 10/01/2012

Registrar

DHMH 17 Rev 06-2011

State

5530 Wisconsin Avenue Suite 1125 Chevy Chase, MD 20815

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bruce R. Kressel, M.D.

OCT 03 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 7% 2012 Martha Yoder 10:23 Pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10606 Bittinger Rd. Bittinger Garrett 5. Social Security Number If Under 1 Year I If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Months Days (Month, Day, Year) 313-34-5519 Director 1 - M 2 - F Dec. 15, 1934 Indiana 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked othar than "natural", or items 23a or 28a-f show other traumatic evant, the Madical Exeminer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Garrett Bittinger 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 10606 Bittinger Rd. 21522 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force 1 Never Married 2 Married Black, White, etc. <u>ک</u> Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Eli J. Hochstetler Sarah J. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any Injury or other to Steve E. Yoder/Son 193 Dick Skinner Rd., Bradford, TN Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Swanton Mennonite Cent. Oct. 10, 2012 Swanton, MD . Signature of Funeral Service Licenses 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart fallure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition reprovas Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to jor as a consuluence of Exam Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death been signed by the s should be detached P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has ball director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☑ No Division of Vital 25. Was case referred to predica 8 26. Place of Death (Check only one) 1 Tes Other: မြ 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Mann f Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director. A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c, License number 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month. Day State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <u>0</u> 1<sup>Day</sup> Physician/ Month 2012 THOMAS JAMES ZAJDEL 18:54P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SHADY GROVE HOSPITAL MONTGOMERY ROCKVILLE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours (Month, Day, Year) Country) Director 196-34-8176 1 1 M 2 □ F 65 Yrs 09/17/1947 PA Usual Residence of Decedent or 28a-f show 10b. County 10c. City. Town or Location Manyland injury or other treumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☑ Yes 2 ☐ No MONTGOMERY POOLESVILLE the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 23a Funeral 20837 17000 HUGHES ROAD USA death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc ö \$ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Il Hygiene. REPAIR TECHNICIAN PHONE COMPANY Be permit. Page 1 and 2 should be filed Department of Health end Mental Hy Importent: If item 27 is marked oth eny injury or other treumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BERTHA KOSIREK THOMAS EDWARD ZAJDEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20837 MARY ZAJDEL / SPOUSE 17000 HUGHES RD., POOLESVILLE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ST. MARYS CEMETERY 10/06/20 2 BARNESVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Foneral Service Licenses 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Acute Medical Due to (or as a consequence of) Examiner 40 Cardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner To the Hospital or Attending Physician: The lew requires that the death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Vascular attending physician and I for use as the burlal-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No å 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No s after death.

I Director: After this conditions on by the funeral director. |₽ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No. 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number MDD72607 1,2012 October 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 MD Medical 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

45×1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month October 2012 1:30 a M ANNIE MARY AKINS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SENATOR BOB HOOPER HOUSE FOREST HILL HARFORD CO. 5. Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. **Funeral** 8 Date of Birth Birthplace (State or Foreign Country) Days Hours (Month, Day, Year) 220**–**42–6<u>680</u> Director 1 □ M 2 🖺 F 71 Yrs. SEPT 9 1941 MARYLAND Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No DARLINGTON MARYLAND HARFORD CO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2503 CASTLETON R R 21034 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐XNo
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 XX ever Married 2 Married Completed by 21215-0036 1 ☐ Yes 2XX No Specify. Specify: 3 Widowed 4 Divorced BLACK 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) A P G BULLENTIN FUNDS Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade JANITORIAL Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOSEPH AKINS GERTRUDE AKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roxanne R. Wright/Daughter Olive Branch Ct., Edgewood, Md., 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) METRO CREMATORY 10-27-12 BALTIMORE, MARYLAND 21. Signature of Funeral Service Lie 2. Name and Address of Facility ILLIAM C BROWN COMM FUNERAL 21 S PHILA. BLVD., ABERDEEN HOME-HARFORD, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause Fitter Indenying Cause (Disease or injury Examine Due to (or as a consequence of): attending physician and for use as the burlal-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month 5 Other (specify) Year After this certificale has been signed by the a funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Tyes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performe Hospital or Attending Physician: The I 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence မ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral is 27. Manner of Death 1 Natural 2 Accident 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🛘 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title se of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 06-2011

				Plea	ise Type or								_		_	ble.	
			For		State	of Mar	yland /	Depa	artmen	t of H	lealth a	and N	lental Hy	/gien	e	1.0	00010
			State Registrar					Cer	tificate	e of E	Death			Reg. N	6. ZU	12	33918
	Physicia Medic		Decedent's Nan		, Last) Elaine Re	iko i	Akaqi						2. Date of Do Month Octobe		ay 2	Year 0 1 2	3. Time of Death 1:50 am
-	Examir		4a. Facility Name (		, give street and nur				4b. City,	Town, or	Location of	of Death	000000		c. County		
Mary and "					y House						Rocku				I	Monte	gomery
	Funeral Director		5. Social Security <b>1</b> 382-48		6. Sex 1 ☐ M 2 🛣 F	7. Age (li	n yrs. last bir	thday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D			9. Birthp Coun	place (State or Foreign try)
			Usual Residence		1 ⊔ M 2 A ∃ F		67	Yrs.					08/2	3/19	945	M.	ichigan
	land show	ģ	10a. State	10b. County		10	0c. City, Tow	n or Lo	cation					-		1	0d. Inside City Limits
	Mary 28a-1 otifie	Director	WA		King						Sear	ttle					1 ☐ Yes 2 🌠 No
	th the 3a or the n		10e. Street and Nu		11 1001				10f. Zip	Code				10g. C	Citizen of W		•
	ath w	Funeral	11. Marital Status	1414 S	outh 1281			112.1	Nos Doord	lank of Lli	9817		nife Van au Na			u.s.	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Examiner must be notified at once.	<b>室</b>	1 Never Mar 3 Widowed		ried Armed Fo	orces? 2 🏹 No ve		I	Yes, spec	ify Cuba	n, Mexican	, Puerto	cify Yes or No Rican, etc.)		14. Race Black Specify:	- Americ k, White, e	
5-(	2 hou "natu	pet	(Sp		nt's Education st grade completed	<u> </u>	16a	. Deced	lent's Usua kind of wor	al Occupa	ation Juring most	of worki	no	16b.	Kind of Bu	siness/Inc	dustry
121	thin 7	Completed	Elementary/Sec		College (1			life. Do	O NOT use	retired)							
d 2	ed wi Hygie other ent, tl	Be (	17. Father's Name	(First, Middle, I				pec	ial E	auca			ENEL e (First, Middle	Maidan			ition
Maryland	be fil ental rked ic ev	2		(,	Takeo A	kaai.					TO. IVIOUR	a S Name	1		i sumame) Iakato		
ary	hould and M s mai	. 12	19a. Informant's N	lame/Relations			198	o. Mailin	g Address	(Street a	and Numbe	er or Rura	I Route Numb				(ode)
Σ	nd 2 saulth a		Kay Mor	i - Dw	lable POA												ton 98057
Baltimore,	of He		20a. Method of Dis		3 🗆 Removal from	State	20b. Place o	of Dispo	sition (Nam	ne of ther place	e)		Date	20c. l	Location - (	City or To	wn, State
Ē	t. Pag tment tant: tant:	Εij		5 Other (S		Otate		inco	en Cr	remai	tory						Maryland
Bal	permit Depar Impor any in		21. Signature of Fu	uneral Service I	icensee Warne	7 1.	232	22	. Name an	d Addres	s of Facilit	y Sim Rock	ple Trib ville Pi	ute l .ke, l	Funera Rockvi	l & Ci lle, i	remation Cente Maryland 20852
			23a. Part 1. Enter shock, or hea	the disease, or art failure. List o	complications that	caused the	e death. Do	not ente	r the mode	e of dying	g, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between
	Physician/		Immediate Cause disease or conditi	ion	a Me	tasta	atic P	anc	reati	c Ca	ncer						Onset and Death Months
-	Medical Examiner		resulting in death)		Due to	(or as a co	onsequence	of):									
		ē	Sequentially list or if any, leading to it	onditions,	b. — Due to	(or as a co	onsequence	ott.					_			_	
	ted ansit	Examiner	Cause (Disease or	erlying r injury		(5. 40 4 5.		J.,.								. (1	y
	oe executed ician and burial-transit	EX	that initiated even resulting in death)		C. Due to	(or as a co	onsequence	of):									<u> </u>
9	ate be hysicia	dical			d												
Box 68760	Attending Physician: The law requires that the death certificate be stream. The law requires that the attending physicator. After this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the b	Completed by Physician/Medic	IF FEMALE:		23c. If yes, out	tcome of r	oregnancy										
X	attendation for us	cian	23b. Was deceden in the past 12	months?	1 🔲 Live	Birth 2	Fetal death		Ectopic p		у			ı	23d. Date Mon		ry Day Year
œ.	he de y the ached	hysi	1  Yes 2 9  Unknow		9 ☐ Unk		ne or dearr		outer (Sp								
P.O.	requires that the der been signed by the a should be detached	ν P	Part II. Other signi	ificant condition	ns contributing to d	death but r	not resulting	in the u	nderlying c	ause giv	en in Part I		23e. Did 1	obacco	use contrit	oute to th	e cause of death?
ds,	quires en sig ould b	ed											10	Yes 2	□ No 3	3 🗌 Prob	ably 4 💢 Unknown
Division of Vital Records,	aw red as ben 2 sho	ple				_							24a. Was				sy findings available appletion of cause of
Re	The law ate has page 2:	ပ္ပြ											perfe	ormed? 2 X N	d€	eath?	
ta	iiclan: The certificate rector, pag	Be	25. Was case reference examiner?		Hospital:						ce of Deat	h (Check					
<u></u>	Physic this cral dir	2	1 ☐ Yes 2 27. Manner of Dea		1 28a. Date		2 ER/O	utpatien Time of			4 🗀 Nu		1177				Hospice
n o	ding th. After fune	Certificate:	1 Natural 2 Accident	5 🗌 Pendir	g (Mon	ith, Day, Ye		injury	м 28	Bc. Injury work?	at ? Yes 2□		28d. Describe	how inju	ry occurred	3	
Sio	Atten r dear sctor: by the	ŧ	3 Suicide 4 Homicide	Investi 6	not be	of Injury	- At home, fa	ırm, stre			165 2 🗆	-	28f. Location (	Street ar	nd Number	or Rural	Route Number,
Σ	s afte		4 🗆 Homicide	determ	buildi	ing, etc. (S	Specify)		•			I.	City or To			Or Fibral	nodic Humber,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director,	Medical	(Check :	2 🗀 Medical E	Physician: To the bax xaminer: On the bax Nurse Practitioner	sis of exam	nination and/o	or invest	igation, in n	ny opinior	n, death oc	curred at	the time date :	and place	and due t	to the cau	se(s) and manner stated
	To the withing to the composite of the c	2	29b. Signature and				St O. my Kilo	.nou je,		License		C GIRL FIRST	and other to		ate signed		
			bod	hard						1	D0060	634					2012
	12M		30. Name and add	ress of person	who completed caus	se of deatl	h (Item 23a) (	Type, P	rint)				<u>l</u>				
	, <u>U</u>		Bindu Jo	oseph,	M.D., 600	1 Mur	rcaste	r M	ill R	oad,	Rock	vill	e, Mar	ylan	d 208	50	
	Sta Registra		31. Date filed (Mon	2 <b>3</b> 2012	Market 32. F	registrar's	Signature	Kent									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 201 **Physician** /Medical Facility Name (If not institution, give or Location of Death 4c. County of Death **Examiner** TIMOVE NO If Under 24 Hrs. 5. Social Security Number (In yrs. last birthday) Birthplace (State dr. Country) **Funeral** 1 M 2 F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County than "natural", or Items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Examinating must be notified at once. 1 Yes 2 □ No Director Bait more mD 10g. Citizen of What Country? 10e. Street and Number 1540 Funeral 21218 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 2 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 工Nta 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ HNOLONSON UNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin 150 RG Kal mother 40 , MD 21218 Underson 10 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 Donation 5 DOther (Specify) 12012 110 21. Signature of Funeral Sc 22. Name and Address of Facility -ASW stad les Funera 34 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. To the Hospital or Attending Physician: The law requires that the death certificate be Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 1 □Yes 2 ☑ No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy performed this certificate 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1-Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 No 1 TYes 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (vem 23a) (Type, Print) Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Philip Alexander Medical Facility Name (If not institution, give street and number **Examiner** 4c. County of Death Age (In yrs. last birthday) If Under 24 Hr 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours unk Director 059-82-7503 1 🛛 M 2 🗆 F 40 Jan 1, 1972 Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a, State 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2 No MD Wicomico Salisbury 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 613 Smith Street #2 21804 USA "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' Black White etc Completed by 1 Never Married 2 Married Maryland 21215-0036 unk 1 ☐ Yes 2 🕅 No Specify: If Yes, Give black 3 Divorced 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business/Industry unk unk (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) fitem 27 i Coastal Hospice at the Lake Deershead Hospital Rd Salisbury, MD 21801 351 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Importants If its any injury or or once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) In state cemetery, crematory or other place) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 1 uneral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Einal Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 SS IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 2 No 9 Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🎾 Unknown page 2 should 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has performed 1 Yes 2\ No the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral D

completely filled i Medical 🗜 🎖 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

Registrar

DHMH 17 Rev 06-2011

State

IFRN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Officed 25gm

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland / Depa <i>Cer</i>	artment of Health <i>tificate of Death</i>	and Mental Hy	rgiene 201	2 33921
	Physicia	n/	1. Decedent's Name (First, Middle, Last	) <u>F</u>	Λ		2. Date of De	eath	3. Time of Death
20.50	Medic Examin	al	4a. Facility Name (if not institution, give	street and number)	1+4	4b. City, Town, or Location	Month OCTC	Ber 20 20	
العمور			PICKERSGIL	L			wson	, ,	ltimore
	Funeral Director		5. Social Security Number  218-01-1286  Usual Residence of Decedent	x □ M 2 🂢 F	(In yrs. last birthday) 100 Yrs.	If Under 1 Year If Under Months Days Hours	er 24 Hrs. 8. Date of Bir Min. (Month, De 08/2	g. Bi	rthplace (State or Foreign Duntry) Unkn.
	land show dat	tor	10a. State 10b. County		10c. City, Town or Loc	cation			10d. Inside City Limits
	e Mary r 28a-i notifie	Director	MD Balti	more	<del></del>		vson		1 No Yes 2 □ No
	with th	Funeral	615 Chestnut Avenue			10f. Zip Code 212	204	10g. Citizen of What C	ountry? SA
	death items ner mu		11. Marital Status	12. Was Decedent E		Vas Decedent of Hispanic Of Yes, specify Cuban, Mexica	rigin? (Specify Yes or No-		erican Indian,
036	s filed within 72 hours after death with the Maryland that hygiene.  33 or 28a-f show of other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ☐ Yes 2 🔯 t If Yes, Give Year or Dates.	Vo.	☐ Yes 2 🛛 No Specify		Specify:	White
2-0	2 hour "natul edical	Completed	15. Decedent's Ed (Specify only highest gra-	lucation		lent's Usual Occupation kind of work done during mo	st of workina	16b. Kind of Business	
121	within 7 giene. er than t, the Me	Com	Elementary/Seconday (0-12)	College (1-4 or 5-	life D	O NOT use retired)  Homemake		Own	Home
nd	filed wall Hyg	Be	17. Father's Name (First, Middle, Last)				her's Name (First, Middle,		
Ŋ	should be fil n and Mental 7 is marked or raumatic ev	욘		harles Frederic				ecelia Norris	
Baltimore, Maryland 21215-0036	2 표 2 급		19a. Informant's Name/Relationship (Ty)  Joseph Albert / Son	oe, Print)		g Address (Street and Numb Allegheny Avenue.			p Code)
ore,	e 1 and of Hea If item		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐	Pomoval from State	20b. Place of Dispos		Date	20c. Location - City of	Town, State
ij	permit. Page Department or Important; If any injury or once.		4 Donation 5 Other (Specify	) 		ake Crematory	10/23/2012	Beltsv	ille, MD
Ba	Depa Impo any i		21. Signature of Funeral Service License Dorota Marshall	8 01	aishall 22	Name and Address of Facil Maryland Cremati	•	Box 1413 Baltir	nore, MD 21203
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on	lications that caused e cause on each line.	the death. Do not ente	er the mode of dying, such as	s cardiac or respiratory ar	rest,	Approximate Interval Between
7	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. ADL	ANCOD consequence of):	Demen	TIA		Onset and Death
	Examiner		Conventially list and diving	Due to (or as a	consequence oi).				
	bd Sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):			53	
	n and al-tran	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):				
092	cate be executed physician and the burial-transit	edical	•	d					
687	certifica anding p use as t		IF FEMALE: 23b. Was decedent pregpant	23c. If yes, outcome of	of pregnancy			Old Data of de	J. San and San and San and San and San and San and San and San and San and San and San and San and San and San
Вох	death o	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live Birth 2 4 Pregnant at 9 Unknown		Ectopic pregnancy Other (specify)		23d. Date of de Month	Day Year
P.0.	nat the ed by th detach		g Unknown  Part II. Other significant conditions co		t not resulting in the u	nderlying cause given in Par	t I. 23e. Did to	obacco use contribute to	the cause of death?
JS, F	uires the signer of signer of the signer of	ed by	CORONARY AT	2 tery [	ISEASE	2			Probably 4 🗆 Unknown
Division of Vital Records,	law rec nas bee	Completed by	OSTEOPOROS	815			24a. Was	psy prior to	topsy findings available completion of gause of
l Re	n: The ficate h		25. Was case referred to medical			20.21	1 🗆 Yes	ormed? death? 2 No 1 Ye	s 2 🗆 No
Vita	ysicial is certi directo	To Be	examiner?	lospital:	nt 2  ER/Outpatien	Other	ath (Check only one)  Jursing Home 5 Resid	dence 6 Other/Spe	rife)
ot	ing Ph After th uneral		27. Manner of Death  1 Natural 5 Pending	28a. Date of injury (Month, Day,	/ 28b. Time of	28c. Injury at work?	28d. Describe h	now injury occurred	
sior	Attend r death ctor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injur	y - At home, farm, stre	M 1 Yes 2 Eet, factory, office		Street and Number or Ru	iral Route Number
D.	tal or after al Dire		4 ☐ Homicide determined	building, etc.			City or Tox		na riodio ivaniboli,
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours afferd eath.  To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 Medical Examin	er: On the basis of ex	amination and/or investi	ccured at the time, date and igation, in my opinion, death o eath occurred at the time, dat	occurred at the time, date a	and place, and due to the	cause(s) and manner stated.
	To the within To the comp		29b. Signature and title of certifier	1 1	/ MA	29c. License number		29d. Date signed (Mont	
			Muchael-	Ho Syri	wom Mil	0, 0463	60	OCTUBER	22, 2012
_	5v		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type, P MO 676)	NORTHCH	ARLES STRE	PAT BAISTIM	22, 2012 1 one MD21204
	Stat Registra		31. Date filed (Month, Day, Year) OCT 2 3 2012		's Signature	,			
	negistra		441 4 - COLC	serving p	· jaguara				

	A	MEN	ID 28A-F,	PER ME	ase Ty	pe or	<b>Prin</b> 23/1	t in B	lack Ir	ndelib	le Ink	k. Ens	ure A	<b>III Copie</b> Ilental Hy	es Ar	e Legib	le.		
		_ •	for State Registrar		`	State C	n Ivia	i yiai iu		tificat			and iv	nemai m	Reg. N	201	2	3392	2
	Physicia	n/	1. Decedent's Nar	ne (First, Middle	e, Last)									2. Date of D	eath			3. Time of Death	Base
5	Medi		Samue1											Octobe	r 3	20 <sup>Y</sup>	[2	11:05 A	VI
	Examir	ner				ive street and number) ce Care, Inc				4b. City, Town, or Location of Death  Towson					4	c. County of Balti		e	
	Funeral		5. Social Security	_	6. Sex	1		In yrs. last	birthday)	_If Unde	r 1 Year	If Under		8. Date of Bi		9	. Birthpl	ace (State or Foreig	חק
	Director		186-50- Usual Residence		1 <b>%</b> N	12□F	54		Yrs.	Months	Days	Hours	Min.	(Month, D			Count	y Carolina	
	and show	or	10a. State	10b. County				10c. City,	Town or Lo	cation			l	march	23,	193050	$\overline{}$	Id. Inside City Limit	
	Maryl 28e-f	irect	MD	How	ard			Co	olumb:	ia								1 ☐ Yes 2 🖾 1	10
	le 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28e-f show or other traumetic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Nu	umber Gentle	Chada	DA:	#101			10f. Zip	Code 1046				_	Citizen of Wha	t Count	ry?	
	ath w	nue	11. Marital Status	———		Was Dece		er in U.S.	13 \				igin? (Sne	cify Yes or No		14. Race -	Amariaa	n Indian	
ဖွ	ter de , or it		1 Never Ma	rried 2 🖾 Mar		Armed For	rces?		) —					ecify Yes or No Rican, etc.)		Black, \	White, e	c.	
21215-0036	turai"	Completed by	3  Widowed		If Yes, Give Year or Dates. 1979			<u>,                                     </u>	☐ Yes			:			Specify: White				
-51:	72 hc in "na Medic	mple	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)			completed)	pleted)			lent's Usu kind of wo O NOT use	rk done d	ation luring mos	t of worki	ing	Kind of Busin	d of Business/Industry			
212	within glene. er the		Liementary/Sec 12	ondary (0-12)		College (1	-4 or 5+)			ad wo						highwa	ıy		
pu	e filed Ital Hy ed oth event	To Be	17. Father's Name	,	amma a l augh								e (First, Middle Sawam		Surname)				
Maryland	ould b	-		el Raymond Barraclough nt's Name/Relationship (Type, Print)					401 44 111					Rural Route Number, City or Town, State					
<b>S</b>	d 2 shoalth an 27 is			A. Barr		,	wif	e		_				eston,	. ,		e, Zip Co	ode)	
ore,	of Her of Her fitem rothe		20a. Method of Dis					20b. Plac	ce of Dispo	sition (Nar	ne of			Date		Location - Cit	y or Tov	n, State	
Baltimore,	permit. Page 1 a Department of I Important: If its any injury or ot		4 🔀 Donation	5 Other (S	Specify)	noval from	State	0011											
Bai	permit Depar Impor any in		21. Signatur	ineral Since I onal	Licens	1	irec	tor	22				-	ite Ana St; Ba	_			1201	
		Н	23a. Part 1. Enter	the disease, or	complicat	tions that o	aused th	ne death.	Do not ente							1010, 1.		Approximate	_
[	hysician/		snock, or neart failure. List only one cause on each line.									Interval Between Onset and Death							
-	Medical Examiner		resulting in death)	Due to (or as a consequence of):  Set 3 cire disorder  Due to (or as a consequence of):										_					
	Zxammor	je	Sequentially list c											-					
	d d ansit	Examiner	if any, leading to i	Due to (	e to (or as a consequence of):  CERTIFICATION APPROVED BY MEDICAL EXAMINER								+						
	executed ian and urial-transit	ai Ex	that initiated even resulting in death)		C	Due to (	or as a c	onsequer	ice of):			1		W APPROVED F	BY MEDIC	AL PARIS	$\top$		_
09/	Attending Physician: The law requires that the death certificate be executed var death.  **rdeath.**  **rdeath.*  **rdeath.**  **rdeath.*  **rdea	adic			d							CE	RTIFICATIV				+		
Box 68760	requires that the death certificate by been signed by the attending physic should be detached for use as the b	Physician/Medic	IF FEMALE: 23b. Was deceden	t pregnant	23c.	If yes, out	come of	pregnanc	у _	,			1/			23d. Date o	f deliver		
Box	death e atte ed for	sicia	in the past 12 1 Yes 2	months?		1 Live I 4 Pregr 9 Unkn	nant at ti		eath 3 🗆 ith 5 🗆	Ectopic     Other (sp		y 				Month		) Day Year	
P.O.	at the d by th		9 ☐ Unknow					not result	ing in the u	nderlying (	rause div	en in Part	1	ana Bid	4-1				
S, P	ires th signe Id be c	d b	hep	=hic +	enci	coh	ماه	pata	14.			C C						cause of death?	vn
ord	w requ	plete	24a. Was an 24b. Were autopsy findings available										9						
Division of Vital Records,	The larate ha	Completed by										-		perf	opsy ormed? 2 14	deat	to com h? Yes 2	pletion of cause of	
ital	ician: certific rector,	Be	25. Was case refer exeminer?		Hosp	oital:						ce of Dea	th (Check						_
∑ <	Phys r this eral di	e:	1 Yes 2 27. Manner of Dea			1 L	of injune	25	VOutpatien		Othe 8c. Injury	_ 4 ∐ No		me 5 Res				ECT FELL	_
ono	anding eath. or: Afte he fun	ficat	1  Natural 2 Accident	5 ☐ Pendir Investi 6 ☐ Could	gation	(Mont Septen	th, Day, 1	(ear) 2 D (	14 injury		work:			Feet	<b>VO</b> 0	A FW	1 F	ROM TREE	
Visi	or Atte	Certificate:	3 ☐ Suicide 4 ☐ Homicide	28e. Place		- At home	e, farm, stre		, office		28f. Location (Street and Number or Ru City or Town, State) UNK								
۵	spital	cal (	29a. Certifier	1. Certifying	Physicia				ne death o			date and		1024	Tento	e Stede	2 1 6	Columbic.	M()
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	(Check	2 Medical E 3 Certifying	xaminer:	On the bas	is of exar	mination a	nd/or invest	igation, in r	my opinio	n. death or	ocurred at	the time date	and place	e and due to	the cause	a(e) and manner eta	ted.
_	S S S S S S S S S S S S S S S S S S S		29b. Signature and	title of certifier	r					29c	. License		~~			ate signed (M			
			- N	rail	<u>~~</u>	<u> </u>		u a:			U	583	0 3		OCF	DACE 3	3 2	012	
_			30. Name and add		who comp		e of deal	th (Item 23	sa) (Type, P ⊃i N	nint)	mal.	, (	- T	אריין אינר	M	0			
	Sta	ı.e	31. Date filed (Mon	- 1 00	,		egistrar's	Signature		اد مد	VILLE	3	1	Mosind		•/			
DI.	Registra	_		ICT 23	2012	100	MA	<u> </u>	130						_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ANKS 0220 M 20/2 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Mandrin Hospice House Harwood Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 8. Date of Birth Days Hours Min (Month, Day, Year) **Director** 225-01-2950 1 🗆 M 2 🕱 F 96 Dec. 25, 1915 Virginia er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Maryland Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20774 USA 17410 Claggett Landing Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. þ Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 🟋 No Specify: Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry filed within 72 h al Hygiene. d other than "na (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Wythe County Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools Dietician e 1 and 2 should be filed wir of Health and Mental Hygie If item 27 Is marked other or other traumatic event, <u>tt</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Esther Umberger John Henry Huddle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17410 Claggett Landing Upper Marlboro, MD 20774 Aurelia Banks Pickett/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. | 10/19/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society fo Maryland, Inc 21. Sig Funeral Service LicenseeStephanie Custer 299 Frederick Road, Baltimore, maryland 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Beath Immediate Cause (Final ₽nysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) MANOR IN examiner? Other: 4 Nursing Home 5 Residence 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print) Co E State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thelma L. Bossle October 18, 2012 5:45p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens Catonsville **Baltimore** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F 93 Days Hours June 24, Year 1919 Director 215-07-5805 Maryland Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location filed within 72 hours after death with the Maryland 10d, Inside City Limits Director 1 Yes 2 X No Maryland | Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 719 Maiden Choice Lane 21228 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔏 No white Specify. 3 ₩ Widowed 4 Divorced "natural" Completed Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Home Maker Own Home Be 2 should be. → Mental H 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edgar Clinton Knapp Edna Rebecca Wicks 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marge Calcara/ daughter 38 Westbrook Lane Palm Coast,Florida 32164 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 10/20/2012 | Baltimore, Maryland of Funeral Service Stephanie Custer 22. Name and Address of Facili Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ oneumon disease or condition Medical resulting in death) ue to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed Cause (Disease or impury that initiated events tran and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown nas been signed by 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has I page 2 No 1 ☐ Yes 2 ☐ No Yes funeral director, Be B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes မြ 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending nours after death.

neral Director: Aft
filled in by the fur Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number R165717 10/19/12 Bunkharat 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP istin narat

State Registrar 32. Registra s Signa

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			1d / DC	Certificate of L	nealth Death	and went	ıaı Hyg	liene			
Physic	cian	1 Decedent's Name (F	irst, Middle L	.ast)					12.	Date of De	Reg. No.		3. Time of Death
Medical Exar	nine	TOOLL C DO							- 1-	Month October	Day	Year	1046 hrs
		4a. Facility Name (if no 215 N Freedor	t institution,	give street and num	ber)	4b.	City, Tow	n, or Location o	f Death			unty of Dea	
Funera		5 Social Security Numl		Sex 7			Havre de Grace				Harfo	ord	
Directo					Age (In y	rs. last birthday)	If Under 1 Months			B. Date of B	rth(MM/DD/Y	YYY) 9. B	irthplace (State or
	4	215-56-03. Usual Residence of Dec		X M 2 F		62 Yrs.	WIOTHIS	Days Hours	Min.	05/31	/1950	Fore	ountry) Mary lan
any			County		100.0	City, Town or Location							
*	_	MD	Harfo	rd									10d. Inside City Limit
daryland 28a-f show	5	10e. Street and Number			П	avre de Gr		4.					1 X Yes 2 N
th the Maryland 23a or 28a-f sho notified at once.	Director	215 N. Fre	mobac	Lano		10f. Zip Code				1	0g. Citizen o	untry?	
with us 23	la la	11. Marital Status	caom	12. Was Deced	ent Ever in	TUS 13 Was F	2107		-0/0		U.S.A		
death or iter	Funeral	1 Never Married	2 Marrie	1 4	es?	If Yes, specify Cuban, Mexican, Puer				y Yes or No an, etc.)		Race - Amer Vhite, etc.	rican Indian, Black,
after	by F	3 Widowed 4	ed If Yes, Give Year			s 2 X	No specify:			Space	+		
hours matur Exam			only highest grade	completed	) 16a Decedent's I	Jsual Occ	upation (Give kir	nd of work	work done 116t		of Business/		
36 in 72 han " lical	ompleted	Elementary/Secondar	y (0-12)	College (1-4	or 5+)	during most	of working	life. DO NOT u	se retired)				y
-00- I with giene ther t	E	17. Father's Name (First	Midello Las	4		Teach	er					lucati	ion
21215-0036 uld be filed within 72 hours afte. Mental Hygiene marked other than "natural", cevent, the Aledical Examines	Be C	Franklin	, Middle, Las Ande		olth			18 Mother's	Name (Fir	st, Middle, N	Maiden Surna	ime)	
212 buld b Ment mark	To B	19a Informant's Name/R			TUI	10b Mailing Ad	4	Franc	ces	Н	avilan	ıd	
and 2 shou lealth and Mitem 27 is n		Elizabeth			er	1220 Ma	oress (S	ake Aver	er or Rural	Route Num	ber, City or T	own, State	, Zip Code)
Fe, and Heal		20a. Method of Disposition			201	b. Place of Disposition	(Name of	cemetery.	Da				Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner most be notified at once		37	remation 3	Removal from	State	crematory or other p	olace)						
Balti permit Departm Importa		21. Signature of Funeral	ther Specify	nsee	A	natomy Gifts				/2012			Maryland
				1/2		7500	Con	ress of Facility	Anato	my G1	rts Re	gistr	Y ND 21076
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate Inter											
/Medical Examiner		Immediate Cause (Final disease a ASphyxia Between Onset an										Between Onset and	
The Property of		Due to (or as a consequence of):										Death	
a supplied	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of).											
	į	cause Enter Underlying (Disease or injury that ini	Cause	Due to (or as a con	sequence	of).							
ed	Examine	events resulting in death)	Last	Due to (or as a con	sequence	of):							
760, Trate be executed physician and the burial - transit		UNPENDED	d										
760, ficate be of g physicia the buria	ledical			AMENDED									
	75 1	IF FEMALE: 23b. Was decedent pregna	ant in the	23c. If yes, outco	me of pre						23d Date	of delivery	
Box 68 e death certif the attending ed for use as	siciar	past 12 months?		4 Pregnant a	t time of	2 Fetal de		3 Ectopic pre	egnancy		Month	Da	ay Year
the ed f	£L	1 Yes 2 No 9 Unknown 9 death 5 Other (Specify)									1		
P.O.	by P	Part II. Other significant	conditions	contributing to dea	th but not	resulting in the underl	ying cause	e given in Part I.	- 2	23e. Did tob	acco use con	tribute to th	ne cause of death?
duires									_	1 Yes	2 <b>✔</b> No 3	3 Proba	ably 4 Unknown
Records, The law require ficate has been si, page 2 should b.	Completed								2	4a Was an	24b.	Were auto	ppsy findings available
Rec The I	팅								-	perform	ed?	death?	mpletion of cause of
tal R	Be	25. Was case referred to n	-				26.Pla	ce of Death (Che	eck only or	Yes 2	V No	1 Yes	2 No
of Vital Ing Physicians free this certifineral director.	2	1 <b>✓</b> Yes 2 N	o   H	ospital: 1 Inpatie	ent 2	ER/Outpatient 3	DOA	Other:	rsing Hom		esidence 6	✓ Other:	Scene
O 50 THE	<u></u>	27. Manner of Death  1 Natural		28a. Date of Inju	лгу (ear)	28b. Time of Injury	28c Inj	jury at Work?	28d. [	Describe how	w injury occur	rred	
Division tal or Attendir rs after death al Director: A	ertification	2 Accident	Pending Investigation	n Oct 15, 2012		FOUND: 1033 hrs	1	Yes 2 ✔ No	Subje	ect inhale nd his he	ed helium	and plac	ed plastic bags
Divi	1	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28							28f. L	28f. Location (Street and Number or Rural Route Number, City			
lospit Hour Unera	ob	4 Homicide 29a Certifier	determined	(Opecity) Sir					215 N	Freedom	e) Lane., Hav	vre de Gra	ace MD
Divi	0	(Check only 1 Certify	ing Physicia Il Examiner:	n: To the best of m	y knowled	ge, death occurred at	the time, o	date and place, a	and due to	the cause(s	s) and manne	er as stated	
To the within To the compl	₩ 2	29b. Signature and title of c		and manner stated	THITIALIUTT A		ту оріпіо	n, death occurre	ed at the ti	me, date an	d place, and	due to the	cause(s)
		and)					29c. License number				9d. Date sign	ned (Month	, Day, Year)
<b>7</b>	3	0. Name and address of	arson				U.C	M.E.			October 16, 2012		
_		O. Name and address of po Ana Rubio M.D., F		mpleted cause of d Assistant Medic			nitim -	- Ct ! -					
Sta	te 3	1 Date filed (Month, Day,)		32. Regulira			ailli non	e Street, Bal	itimore,	MD 2122	23		
Registr			2 3 20	12 /		A born							

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month Frank 23:44 PM OCTOBER 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SINAI HOSPITAL OF BALTIMORE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Days Hours Director 1 **2** M 2 □ F 212-52-3427 Usual Residence of Decedent 63 Jan 01, 1949 Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, <u>the Medical Examiner must be notifled at</u> 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Direct 1 ☐ Yes 2 No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 701 Edmondson Ave 21228 United States Fun 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hyglene Important: If frem 27 is marked other that any injury or other transmissions. Construction Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Joseph Charles Baum Marie Anastasia Antonete Kankosky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Hutson /Daughter 23195 Edelen Webster Rd. Deal Island, MD 21821 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Oct Beltsville, Maryland 2012 Chesapeake Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Cremation and Funeral Alternatives MO1585 Rebacc Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ADVANCED COPD 50 YEAR Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physicien and Cause (Disease of Injury that initiated events attending physicien and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 5 Other (specify) Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed HMRZKTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy 1 ☐ Yes 2 ☑ No Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Yes ဥ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) RES-000 0 CTOBER 19, 2012 MBBS address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar ASHRIT

SINAL HOSPITAL OF BALTIMORE

MBBS

32. Registra/s Signat

MULTAM.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Helen Marie Buettner 4:13 P.M <u>October</u> 19, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford Edgewood 1402 Willow Oak Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) 212-26-2553 Director 1 🗆 M 2 😾 F 81 Yrs. November 24, Maryland 1930 27 is marked other than "natural", or items 23a or 28e-f shov traumetic event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Edgewood Maryland Harford 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g Citizan of What Country? United States Funeral 21040 1402 Willow Oak Road of America 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò 1 ☐ Yes 2 ZZNo If Yes, Give 1 ☐ Yes 2xxxNo Specify. white 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home . Page 1 and 2 should be filed with ment of Health and Mental Hygie tant: If item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) စ္ Clinton Hendrickson Ethel Cursey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mr. Mark Buettner/ son 1404 Willow Oak Rd. Edgewood, Maryland 21040 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 23 permit. Page 1
Department of I
Important: If it
any injury or of cemetery, crematory or other place) Evans Funeral Chapel – Bel Air 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2012 Forest Hill, Maryland 21. Signatur Fundal Service Li 22. Name and Address of Facility
Peaceful Alternatives Funeral and Crematicn Center, P.A.
2325 York Road Timonium, Maryland 21093 Fart 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Cerebral Vascular diseace Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to or as a consequence of the attending physician and thed for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the deeth certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month ate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform Yes 2 1 Yes 2 No 24 hours after death.

Funeral Director: After this certifics letely filled in by the funeral director, 8 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certifier 29c. License number H41069 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #102 Edge wood Stanley 31. Date filed (Month, Day, Year) State 3 OCT 2 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend 25, per me, g932 10-23-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3928 Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gi Zoo Bai 10:38 October 0 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 5308 Dunteachin Drive Howard Ellicott City Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 226-25-0042 **Director** 1 X M 2 □ F 92 2/5/1920 Korea Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director MD Howard Ellicott City 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 5308 Dunteachin Drive 21043 U.S.A. or items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: "natural", Specify: Asian 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than " College (1-4 or 5+) Elementary/Secondary (0-12) Reverend Christian Church and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Hyun Jung Bai Hunsoo Park permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther Choi /Daughter 5308 Dunteachin Drive, Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Donation 5 Other (Specify) cemetery, crematory or other place) National Memorial Park Falls Church, VA 10/20/2012 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funera St Funeral Home of Catonsville, Inc. 1630 Edmondson Ave., Catonsville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Nech Medical Due to (or as a consequence of) **Examiner** MENTON APPROTED BY MEDICAL ELAWART oronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) physician a sthe burial-Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 Unknown 9 Unknown P.O. signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, cate has been sig ; page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏋 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hospital or Attending Physician: The law I 24 hours after death, performed?

Yes 2 No certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 XYes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) To the Hospitan .
within 24 hours after death.
To the Funeral Director: After thi 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred ☐ Natural 5 Pending 1 Yes 2 No fall from bed 2 Accident 3 Suicide unk Investigation 10/15/2012 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 5308 Dunteachin Dr. Ellicott Cit SMOH Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. No 31049 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tonh 412 NL 31. Pate filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARGARET BOONE OCTOBER 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No must be notified Directo Da / HIMOR 28a-f 10e. Street and Number 10g. Citizen of What Country? Funeral filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify Specify: 3 Widowed 4 ☐ Divorced NK to Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Homenakir OWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be UNKNOWN ည UN KNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BOONE POND CITCLE MD 21234 James 45 Deaver 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important; If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) LAWN CEMERNY 10/18/12 Balkmore 22. Name and Address of Acility 21. Signature of Funeral Service Licensee adley - Ashton Funcal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEMATOMA SUBDURAL Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** DWAPPROVED BY MEDICAL EXAMINER FALL Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical CERTIFICAT 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? |Live birth 2 | Fetal dea | Pregnant at time of death Month Year Day 1 Yes 2 No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, PIBRILLATION 1 🗌 Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? CORONARY ARTERY DISEASE autopsy performed CHRONIC OBSTRUCTIVE PULMONARY DISEASE 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Mapatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \sum Nursing Home 1 Yes 2 □ No 5 Residence 6 Other (Specify) ၉ 28a. Date of Injury
(Month, Day Year)
CCTOBER 13 2012

Un known

Market 28c. Injury at Work? 27. Manner of Death Certification; 5 Pending investigation -all trom 1 🗌 Yes 2 Accident 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Ru City or Town, State) by 4 Homicide Store 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (check only Medical and manner stated

24 hours

within 24 hor To the Fune completely fi

29d. Date signed (Month, Day, Year) RES-000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IVAN KOTCHETKOV

4940 Eastern Avenue, Baltimore, MD, 21224

OCTOBER

15 2012

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

32. Registrar's Signature

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201<sup>Year</sup> October 13, 4:00 AMM Woodsie Jonetta Bradley Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Timonium Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 6 Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Min. Hours Director 218-28-4770 1 ☐ M 2 🂢 F Yrs Dec 6, 1930 Virginia 81 28e-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Parkville 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23e Funeral 3007 Edgewood Avenue 21234 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. "neturel", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【 No Specify: 3 ☐ Widowed 4 \( \overline{\mathbb{M}}\) Divorced Year or Dates white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) end Mental Hygiene. Is marked other then Elementary/Secondary (0-12) College (1-4 or 5+) 12 phlebotomist healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be John Clayton Bradley Sr Etta Sensibolle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Heelth en Important: If item 27 is any injury or other treu 3007 Edgewood Avenue Baltimore, MD Janice Frederick/daughter OCTOBER 13, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Pege 1 cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Cher (Specify) . Signat ire of Tuneral Service <sup>23</sup> Name and Address of Facility Board 655 W. Baltimore Street MD 21201 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) DEMENTIA Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sicien end buriel-transit Exami or Attending Physicien: The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ettending physicien for use es the burie Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery WOODSIE BRADLEY 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 🗶 No Pregnant at time of death Month cate has been signed by the ( ) page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 Unknown Completed 24a. Was an . Were autopsy findings available prior to completion of cause of autopsy this certificate 1 ☐ Yes 2 ☐ No ☐ Yes director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6X Other (Specify) ည 2 💢 No To the Hoepitel or Attending Physi within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 IDOA HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Suicide 1 🗌 Yes 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🛮 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP 2300 DULANEY VALLEY RD. TRACIE L. MORGAN, TIMONIUM, MD 21093

State

Registrar

31. Date filed (Month, Day, Year)

3 2012

32. Registrar's Sig

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. nend #9 state of Maryland Department of the arm and Member 1993 and 1997 2012

eginald A. B	оок		Registrar	partifientol ertificate of			'Me <del>nt</del> a	al <b>YH</b> y?		eg. No. 2	012 33	93	
Physi ledical Exa			1. Decedent's Name (First, Middle,Last)  Reginald A. Booker						Date of Dea Month Septembe	oth Day Yea er 19, 2012	3. Time of Dea 0000 hrs		
			Facility Name (if not institution, give street and number)     12204 Edgemont Street		b. City, To Silver		ocation of			4c. County of Montgor	mery		
Funera Directo			unit la la la la la la la la la la la la la	s. last birthday)	If Under Months	1 Year Days	If Under	24Hrs, Min.			9. Birthplace (State or Foreign Country)	unk	
any			Usual Residence of Decedent	ity, Town or Locati					Jan 3	, 1953	10d. Inside City	v Limits	
<b>E</b>	once.	وَ	MD Montgomery	Silver Spring							1 Yes 2	-	
the Mary	notified at once	Director	10e. Street and Number  12204 Edgemont Street		10f. Zip Code 20902					0g. Citizen of Wh			
leath with	ust be no	Funeral	11. Marital Status 12. Was Decedent Ever in		If Yes specify Cuban Mexican Puerto					14. Race White	- American Indian, Blac e, etc.	ж,	
urs after o	의	의	3 Wildowed 4 Divorced in tas, diversal 1 Yes 2 1 No specify: D1a									unk	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.  Int: If item 27 is marked other watural", or items 23s or 28s-f she	the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		ost of worki	ng life. D	O NOT us				omery Colle		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. In frem 27 is marked other than important: If item 27 is marked other than an an arked other than a standar	nt, the M	Be Con	17. Father's Name (First, Middle, Last)  Rudolph Booker		-unl	18			irst, Middle, I	_l Maiden Surname) <b>lount</b>	) -	ink	
MD 21; nd 2 should be ulth and Men m 27 is mar	matic eve	٩	19a. Informant's Name/Relationship (Type, Print ) Gina Robinson-cousin	19b Mailing	Address Dunag	(Street a			_		30043 Code) MD 21223	<u></u>	
Ore, Nges 1 and 1 of Health	ther trau			b. Place of Disposi crematory or oth	tion (Name				Date		City or Town, State		
Baltimore, permit. Pages 1 an Department of Healinportant: If the	ilary or o	ł	4 ponation 5 X Other Specify: in State  21. Signature of Funeral Service Licenses  Ronald S Wade Sixest	or 32. N	ame and A	ddress o	fFacility	nard	655 W	Raltin	nore Street		
Physicia	n	4	23a. Part I. Enter the disease, or complications that caused the deafalure. List only one cause on each line.									Interval	
/Medica Examine			Immediate Cause (Final disease or condition resulting in death)  a Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):										
	۱	je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): causs: Enter Underlying Cause										
cuted	1181	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
O, e be execut sician and	burran - uran	edical	UNPENDED AMENDED										
Box 68760 death certificate the attending physical death of the attending physical death at the hold of the hold death at the hold death at the hold death at the hold death at the hold death at the hold death at the hold death at the hold death at the hold death at the hold death at the hold death at the hold death at the hold death d			IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pr	2 Fet	al death	3	Ectopic p	regnanc	у	23d. Date of Month	delivery Day Ye	ear	
Box ne death c the atten	sn Ioi na	Pre-MALE:   23b. Was decedent pregnant in the past 12 months?   1											
Division of Vital Records, P.O. Box 68760,  Hospital or Attending Physician: The law requires that the death certificate be exceuted to hours after death.  24 hours after death.  Figure 1 in rectors. After this certificate has been signed by the attending physician and refuse fined in rectors.		בּ	Part II. Other significant conditions contributing to death but no	contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause  1 Yes 2 No 3 Probably 4			
Division of Vital Records, tal or Attending Physician: The law require is after death.  Director: After this certificate has been side in br. the financh data in the financh data the financh da	mous 7 a	Completed								osy p rm <u>ed</u> ? d	Vere autopsy findings av prior to completion of cau death?		
Vital Recysician: The his certificate	ctor, page	용 음	25. Was case referred to medical 26.Place of Death (Check only one)									No	
ing Physic	2 I	의	1 ✓ Yes 2 No Inspire 1 Inpatient 2 27. Manner of Death 28a. Date of Injury	ER/Outpatient 28b. Time of Ir			her <sub>4</sub> N at Work?			Residence 6 v			
rision r Attendi er death. rrector:	oy the It	Certification:	Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number of Rural Rou								er. City		
Division  Hospital or Attend 24 hours after death Funeral Directors			Suicide Could not be determined (Specify) or Town, State)										
4 Homicide (Specify)  29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as some one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as some one)  29b. Signature and title of certifier									ue to the cause(s)				
		≥	29b. Signature and title of certifier	MI		icense r D.C.M.				29d. Date signe September	r 20, 2012		
		,	30. Name and address of person who completed cause of death (Its Russell Alexander MD. Assistant Medical Exa		N. Baltin	nore S	treet, B	altimo	re, MD 21	223			
Regi	Sta istr	te ar	31. Date filed (Month, Day, Year) OCT 2 3 2012 32. Registrar's Sign										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 33932 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 20, 2012 5:15 P JD Baker Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford 1611 Michelle Ct. Forest Hill Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 230-28-6170 1**X** M 2 □ F Director 85 Sept. 4, 1927 Virginia or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🎦 No Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 1611 Michelle Ct. Apt. C 21050 USA 12. Was Decedent Ever in U.S. Armed Forces? 1♣ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: 3 X Widowed 4 □ Divorced Specify Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. 27 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) 12 State Highway Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk) (unk) (unk) Bessie (unk) Baker other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important; If item 27 is any injury or other trau Bill Mul<u>lins / Nephew</u> Sharon Road, Jarrettsville, MD 21084 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State Highview Memorial Gdn 10-23-2012 | Fallston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) McComas Funeral Home, P.A. f Funer 22. Name and Address of Facility 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ueur Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exam and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ğ in the past 12 months? Day Year Pregnant at time of death Yes 2 No detached 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Mronic has autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one)

that the death certificate be Division of Vital Records, P.O. Box 68760

Maryland 21215-0036

Baltimore,

within 24 hours after death.

To the Funeral Director; After this certificate to completely filled in by the funeral director, page To the Hospital or Attending Physician:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print 718 Nornis

28a. Date of injury (Month, Day, Year)

Hospital

20/2 22

Other: 4 Nursing Home 5 X Residence 6 Other (Specify,

28d. Describe how injury occurred

City or Town, State

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month.) Dav. Year)

State Registrar

1 \( \text{Yes}

27. Manner of Death

1 Natural

4 Homicide

29a. Certifier

(Check

Accident Suicide

29b. Signature and title of certifie

မ

Certificate:

Medical

filled in by the

2 No

5 Pending

Investigation 6 Could not be 1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

injury

28c. Injury at

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 30 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Barbara Hinton 2:00 A<sup>M</sup> Bragg October 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sanctuary at Holy Cross Burtonsville **Burtonsville** Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Director 237-64-9890 1 □ M 2 🗓 F 71 March 6,1941 North Carolina Usual Residence of Deceden or than "natural", or Items 23a or 28a-f show the Medical Examinar meat be notified at 10a. State 10h County 10c. City, Town or Location Director 1 X Yes 2 □ No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15101 Interlachen Drive #706 20906 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 I and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Government 5+ <u>Information Specialist</u> Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Herman Hinton Elnora Arrington 1 and 2 should be if Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Giles Bragg/Son <u>7825 Paddock Way Baltimore,</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Riverdale Crematory 4 Donation 5 Other (Specify) 10-26-2012 Riverdale, Maryland 21. Signature @Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. kuas 7474 Landover Road, Hyattsville, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Metastic Cancer Unknown Primary Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the effect. that initiated events Due to (or as a consequence of): resulting in death) Last Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> ieral Director. After this certificate has been signe filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending 1 Yes 2 No Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in trip spiriture, seath occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0064100 October 19, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Bhikkaji

Smitha

Glen Road Silver Spring, MD 20910

Forest

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33934 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 201<sup>Yea</sup> October <u>Venkataramany</u> 21 3:35 P.M <u>Balakrishnan</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1068 Pipestem Place Potomac Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours Min. Director 226-59-6711 1 X M 2 □ F 83 August 27,1929 Usual Residence of Decedent India is than "naturel", or Items 23a or 28a-f show the Madical Examiner must be notified at be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland | Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1068 Pipestem Place 20854 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married þ 1 ☐ Yes 2 🕅 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Asian Indian Completed 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If Item 27 Is marked other than 'iury or other traumatic event, the Maiury or other events Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Financial Controller Oil Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ramachandra Kamakshi Balasubramanian Venkataramany 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1068 Pipestem Place, Potomac, MD 20854 Bhama Balakrishnan / wife 20a. Method of Disposition 20b. Place of Disposition (Name of October 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 D Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once, 4 Donation 5 Other (Specify) Montgomery Crematorium 2012 Bethesda, MD 21. Signature of Funeral Service License Robert and Adram phresylv Funeral Home, Bethesda-Chevy Chase, Inc. <u>€M</u>01099 <u>7557 Wisconsin</u> Bethesda, MD 20814-3501 Avenue. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Cardiac Arrest Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The lew requires that the death certificate be executed attending physician and I for use es the burial-trans! Cause (Disease or injury that initiated events resulting in death) Last Congestive Heart Failure Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Year been signed by the a should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by paralysis agitans 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy
performed?

Yes 2 1 No this certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural iniury work? 1 ☐ Yes 2 ☐ No I Director: A Accident Investigation Suicide 6 Could not be filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) D0037532 October 22, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50 West Edmonston Drive, #202, Rockville, MD 20852 Praveen K. Gupta, 31. Date filed (Month, Day, Year)

OCT 2 3 2. Registrar's Signature State Registrar

X DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 19, Lucille 2012 Alice 7:45 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Collingswood Nursing Center Montgomery Rockville 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 418-20-8578 Director 1 🗆 M 2 🔼 F 91 October 28, 1920 South Carolina ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If fine 27 is marked other than "naturo": 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Germantown 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20335 Waters Row Terrace 20877 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force 1 ☐ Yes 2 🕅 No If Yes, Give 1 Never Married 2 Married Black, White, etc. à 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Specify: Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed Elementary/Secondary (0-12) College (1-4 or 5+) Admitting Clerk Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Will Garlington Elsie White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20335 Waters Row Terrace, Germantown, Maryland 20874 Sadie Bone / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 1 X Burial 2 Cremation 3 Removal from State All Souls Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 29, 2012 Germantown, Maryland 21. Signature of Fu Service Licensee 22. Name and Address of Facility Funeral Home/Rockville, Inc. Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01305 23a. Fart / Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ Cerebrovascular Accident Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or migny that initiated quants. Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No 5 Other (specify) Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Dementia Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No After this certificate 1 Yes 2 No 25. Was case referred to medical 8 26. Place of Death (Check only one) Hospital Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Director: A d in by the f Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D37801 October 22, 2012 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 20850 15020 Shady Grove Road, Ste. 300, Rockville, Maryland Aimee J. Seidman, M.D. 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 18 2012 Year FLORENCE L. BURNS 4:40 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CALVERT MEMORIAL HOSPITAL CALVERT PRINCE FREDERICK Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Hours **Director** 169-16-8202 1 □ M 2 🗓 F JUNE 19, 1921 PENNSYLVANIA 91 Usual Residence of Decedent works. ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MARYLAND CHARLES LAPLATA 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 100 ORIOLE LANE 20646 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 Divorced Specify: WHITE Year or Dates th and Mental Hygiene.

27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 GLASS WORKER GLASS MANUFACTURING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ANDREW MARCINKO ANNA CICH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i PATRICK A. BURNS 100 ORIOLE LANE, LAPLATA, MD 20646 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date 1 Burtal 2 X Cremation 3 Removal from State cemetery, crematory or other place) METROPOLITAN CREMATORY 10/19/12 5 Other (Specify) 4 Donation ALEXANDRIA, VA 21. Signature of Dineral Service License 22. Name and Address of F. METROPOLITAN 5517 VINE ST. Facility FUNERAL SERVICE , ALEXANDRIA, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph. sician no disease or condition Medical resulting in death) Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying as a consequence of Examir the burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) After this certificate has been signed by the atter funeral director, page 2 should be detached for in the past 18 months? Day Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Was a. autopsy performed 24a, Was an 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 No ဂ္ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Dea h e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify)

State

31. Date filed (Month, Day, Year, 23

Registrar

Medical

29a. Certifier

29b. Signa

(Check

only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #25, per me, g932 10-24-12 sm. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MICHAEL Physician/ 1931 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death TIMURE HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Hours 216-13-5772 **Director** 32 1 XXM 2 □ F bet. 15, 1980 Maryland ral", or items 23a or 28a-f show Examiner must be notified at 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XXVo Baltimore Highlands Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 United States 2920 Virginia Ave. death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Who 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian or : 1 XX ever Married 2 Married Completed by 1 Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: "natural", Specify: 3 Divorced 4 Divorced White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than College (1-4 or 5+) N/A Elementary/Secondary (0-12) 12th Forklift Operator Construction marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Frederick H. Bealefeld Jacquelyn R. Staiger and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Frederick H. Bealefeld /Father 2920 Virginia Ave., Baltimore Highlands, Maryland21227 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State Oct.23,2012 Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) e of neral Service Licenses 22. Name and Address of Facility BROSE FUNERAL HOME OF LANSDOWNE 2719 Hammonds Ferry Rd. Lansdowne Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician. disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burlal-t nding physician ause as the burlal Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ξ Pregnant at time of death Month Day Year ed by the a 9 Unknown P.O. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has bade 2 s autopsy. performed Yes Division of Vital To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 X Yes ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 DER/Outpatient 3 IDOA 27. Manuer of Death 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer 1 Natural injury 5 Pending work? 1 🗌 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [ and title of certifier 29d. Date signed (Month. Day, Year) D0062804 M address of person who completed cause of death (Item 23a) (Type, Print)
ON SWENCKL, MD 3001 S. HANOVER ST BALTIMORE ND 21225 31. Date filed (Month, Day, Ye State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33938 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Trisha Diane Creekmore October 18, 2012 8:25 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 302 Lincoln Ave. Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min. (Month, Day, Year) Months 548-37-1846 Director 1 M 2 XF 48 Oct.6,1964 California Usual Residence of Deceden ould be filed within 72 nouse with the filed within 72 nouse with marked other than "natural", or items 23a or 28a-f show marke ovent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Takoma Park 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 302 Lincoln Ave. 20912 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. δ Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 XNo If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed Specify Caucasian 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Journalist TV Media or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Paul Smith Suzanne Cogen should end Ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Haaith item 27 i David A. Creekmore / husband 302 Lincoln Ave. Takoma Park, MD 20912 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Paga 1 s
Department of H
Important: If ite
any injury or ot Date Paga 1 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 10/22/12 Woodbine, MD 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 21. Signature of Juneral Service Licensee M01651 Clarksville, MD 21029 Beverly L. Heckrotte. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 6 Months Physician Metastatic Breast Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Prior Breast and Axillary Recurrence 2 1/2 yrs Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Exam or Attending Physicien: Tha law requires that tha daath certificate be axecuted attanding physician end i for use es tha buriai-trensif Prior Stage I Breast Cancer 8 yrs Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an s cartificata hes t director, pega 2 s performed? Yes 2 No 1 Yes 2 X No 25. Was case referred to medical funaral director, 品 26. Place of Death (Check only one) Hospital Other: 유 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 😡 Residence 6 ☐ Other (Specify) this To the Hospital or Attending Ph within 24 hours aftar daath. To the Funeral Director: Aftar thi complately fillad in by tha funaral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) D37236 Oct. 19, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carolyn B. Hendricks MD 6410 Rockledge Dr. #506 Bethesda. 31. Date filed (Month, Day, Year) 2. Registrar's Sign State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1, per PHY, g932 10-25-12 sm State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) Mary Eileen Casey Date of Death
 Month 3. Time of Death Physician/ Year ileor 1:30 AM Medical T 201 Examiner 4a. Facility Name (if not institution, give street and numbe 4b. City. Town, or Location of Death 4c. County of Death 4180 Calvert Drive Chesapeake Beach Calvert Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** 1 □ M 2 🛛 F Days 10/24/1957 New York Director 076-54-1901 54 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Examiner must be notified at any injuy or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Chesapeake Beach 1 Yes 2 X No Calvert MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 4180 Calvert Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 X Married 1 ☐ Yes 2 K No Specify. If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 McLaughlin William Joseph Helen Margaret Cornells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Casey / Spouse 4180 Calvert Drive, Chesapeake Beach, MD 20732 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 10/21/2012 Hanover, Maryland 21. Signature of Funeral Service Lice Anatomy Gifts Registry 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ metastalic disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or iinjury that initiated events resulting in death) Last physician and the burial-tran Due to (or as a consequence of) Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) j in the past 12 months Pregnant at time of death Unknown Day Year 1 Yes 2 U Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 4 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 4 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 0 No ၉ Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home this 5 Residence 6 Other (Specify) funeral n 24 hours after death.

e Funeral Director. After the leted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending work? 1 Natural 5 Pending injury 2 No 2 Accident
3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D00177 alm 10,15112 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahin S 370 MZDAMI PO Huntingtown 31. Date filed (Month) State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Physician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit

Division of Vital Records, P.O. Box 68760

within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for u	

	218-56-5	5241	M 2 □ F	84	Yrs.	Months Days	Hours Mir			9. Birthplace (State or Country)  Ital				
ctor	10a. State	10b. County	amaku	10c. City	y, Town or Loca		ink Cost	ino		10d. Inside City				
<u> </u>	Maryland 10e. Street and Num		gomery	L		10f. Zip Code	er Spr	uig			2 M NO			
Funeral Director			ght Drive			Tut. Zip Gode	20903		10g. Citizer	n of What Country? <b>Italy</b>				
۾	11. Marital Status		12. Was Decedent I Armed Forces? 1 Yes 2 X	Ever in U.S	lf '	as Decedent of His Yes, specify Cuban,	, Mexican, Pue	Specify Yes or No erto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify:				
etec	3 Widowed 4	1 ☐ Divorced  15. Decedent's E	Year or Dates.			nt's Usual Occupat			1	of Business Industry				
Completed	(Spec Elementary/Seco	cify only highest gr		5+)	(Give ki	nd of work done du NOT use retired) <b>Barb</b>	ring most of w	orking		th & Beauty				
Be	17. Father's Name (F						18. Mother's N	ame (First, Middle	, Maiden Sun	name)				
욘	40. Informatik No		rello Cica	la				menica D						
	19a. Informant's Na		- Daughter						-	wn, State, Zip Code) , Maryland 20	903			
	20a. Method of Disp	osition	Removal from State	20b. P	lace of Disposi		1	Date		tion - City or Town, State				
	4 Donation	5 Other Speci	ffy)		te of t	leaven Cei	m. 10/			ver Spring, M				
	21. Signature of Fun	reral service (licen		709						uneral Home, Spring,MD 20				
	23a. Part 1. Enter the	e disease, or com failure. List only o	aplications that caused one cause on each line	d the death						Approximate Interval Betw	)			
	Immediate Cause (F disease or condition resulting in death)	inal			y Fail	ure				Onset and D 1 week				
						ive Pulma	пати О	isease.						
Examiner	Sequentially list cor if any, leading to im cause. Enter Under													
Exar	Cause (Disease or in that initiated events resulting in death) L													
dical			d				<u></u>							
₩ē	IF FEMALE:		23c. If yes, outcome	of progner	201									
Physician/Medical	23b. Was decedent   in the past 12 m 1 Yes 2 9 Unknown	nonths?	1 Live Birth 4 Pregnant a	2 Feta	I death 3	Ectopic pregnancy Other (specify)			230	d. Date of delivery Month Day Ye	ear			
			contributing to death b				n in Part I.	23e. Did	tobacco use	contribute to the cause of de	ath?			
leted by	Ischem	ic Cardo	omyopathy	Pneun	noconio.	sis		_ 1 <b>X</b>	Yes 2□	No 3 Probably 4 U	Inknown			
Comple								- auto	s an 2 opsy ormed? 2 <b>X</b> No	24b. Were autopsy findings av prior to completion of ca death? 1 ☐ Yes 2 ☐ No	vailable use of			
Be	25. Was case referre examiner?	_	Hospital:			26. Plac	e of Death (Ch							
e: 10	1 ☐ Yes 2 🗶 27. Manner of Death	<u> </u>	1 ☐ Inpati 28a. Date of inju	iry	ER/Outpatient 28b. Time of	3 DOA Other.	4 ☐ Nursing	Home 5X Res						
ficat	1 Natural 2 Accident	5 Pending Investigatio		y, Year)	injury	M 1 □ Y	es 2 🗆 No							
al Certificate:	3 ∐ Suicide 4 ∏ Homicide	6 ∐ Could not to determined				t, factory, office			(Street and Ni wn, State)	umber or Rural Route Numbe	Ή,			
Medical	(Check 2	Medical Exam	rsician: To the best of liner: On the basis of e se Practioner: To the	examination	and/or investig	ation, in my opinion,	, death occurred	d at the time, date	and place, and	d due to the cause(s) and man	iner state			
	29b. Signature and t	itle of certifier	. 4 ^			29c. License r				igned (Month, Day, Year)	0			
	30 Name and addra	ss of person who	completed cause of d	leath (Item	23a) (Type Pri		D36252		00	tober 19, 201	7			
	Steven	T. Kariy	a, M.D., 1	0605	Concor		#500,	Kensing	ton, M	laryland 2089!	5			
e ır	31. Date filed (Month	, Day, Year) T <b>2 3</b> 201	32. Registra		ure San	20								
	- UL	4 9 401	- Moura	g.	- Court									

	A	ME	ND PI LINE A PER	MD G932 10 State of M	<b>nt in Black</b> /23/12 TR1 arvland / Dei	indelible in partment of l	<b>K. Ensure All</b> Health and Mer	<b>Copies Ai</b> ntal Hygier	re Legible. ne	
		-	State Registrar			ertificate of		Reg. I	2012	33941
7	Physicia Medic		1. Decedent's Name (First, Middle, I	Ε.	Ci	nnamond		Date of Death	7,2012	3. Time of Death 5.17 P. M.
0	Examin	er	4a. Facility Name (if not institution, o	PUICA	Conter	4b. City, Town, o	CA) A		4c. County of Death	5
	Funeral Director		Social Security Number 213–34–1443 Usual Residence of Decedent	. Sex 7. Ag	e (In yrs. last birthday 75 Yrs.	) If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Year Stober 30,	g. Birthp Count Mary	lace (State or Foreign (Y) Land
ے	yland f show ed at	tor	10a. State 10b. County		10c. City, Town or I				10	Od. Inside City Limits
R	the Mar or 28a- e notifie	Funeral Director	Maryland Charle  10e. Street and Number	es	Wald	10f. Zip Code		10g.	Citizen of What Coun	1 🗆 Yes 2 🗶 No
0	th with ns 23a must b	ineral	1101 Hamlin Road				20602		USA	
36/	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	by	<ul> <li>11. Marital Status</li> <li>1 ☐ Never Married 2 ☐ Marrie</li> <li>3 ☐ Widowed 4 ☐ Divorced</li> </ul>	12. Was Decedent 8 Armed Forces? 1  Yes 2  If Yes, Give Year or Dates.		Was Decedent of Factoring     If Yes, specify Cubin     □ Yes 2 X No.	dispanic Origin? (Specify an, Mexican, Puerto Rican Specify:	Yes or No- an, etc.)	14. Race - America Black, White, e	tc.
M-7-	72 hour n "natu fedical	Completed	15. Decedent' (Specify only highest	s Education grade completed)	(Giv	edent's Usual Occup e kind of work done DO NOT use retired,	during most of working	16b	. Kind of Business/Inc	lustry
/W 212	ygiene. ygiene. her tha ht, the N	Be Cor	Elementary/Secondary (0-12) 12 years	College (1-4 or 5	)+) <b>1</b>	nager		Re	eal Estate	
Maryland	uld be filec   Mental H   marked ot     natic even	To B	17. Father's Name (First, Middle, Lat George Wilhelm				18. Mother's Name (Fi Dorothy Br	radley		
Mar	d 2 shou alth and 1 27 is n er traum		19a. Informant's Name/Relationship  Jamie M. Hoffma				and Number or Rural Ro Road, Waldor			
Baltimore,	ige 1 an nt of He t: If item		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3	□ Removal from State		ematory or other pla		er	Location - City or To	
I I T	ermit. Pa epartme nportan ny injun		4 Donation 5 Other (Sp. 21. / Ign.: ure of Europe and Service Lic	-	) ()	vn Cemeter	Y 12, 20 Funeral Hon		ltimore, M ndalk.P.A.	aryland
2	20 E # 9	- 12	23a. Part 1. Enter the disease, dr c	omplications that caused	the death. Do not e	1110 POTT	ers Point F	koad, Dui	ndalk,MD.	21222 Approximate
5	Physician .	E 33	shock, or heart failure. List on Immediate Cause (Final disease or condition	y one cause on each line	C OA	-0	0	PSIS		Interval Between Onset and Death
3	Medical Examiner		resulting in death)	Due to (or as	a consequen of):					
	sit q	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):					
7	be executed sician and burial-transit	Exar	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
	certificate be nding physicie use as the bu	edical		d						
) š	death he atte ed for	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	☐ Ectopic pregnan☐ Other (specify) _	су		23d. Date of delive Month	ry Day Year
	s that the gned by tl oe detach	by Ph	Part II. Other significant condition	s contributing to death b	ut not resulting in the	e underlying cause gi	iven in Part I.		o use contribute to the	
Records,	requires been sign should be	eted					l			ably 4 Unknown
- Seco	ician: The law certificate has I rector, page 2 a	omp						24a. Was an autopsy performed'	prior to cor death?	esy findings available inpletion of cause of
da la	sician: certifica irector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:		Oth	lace of Death (Check onliner:	ly one)		
\$ 6 (V)	ng Phys fter this uneral d	ate: To	27. Manne of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of inju (Month, Da	ent 2 ER/Outpat ry 28b. Time v, Year) injury	of 28c. Injur	4 □ Nursing Home ry at 28d	5 ☐ Residence  Describe how in	6 Other (Specify) jury occurred	
Division	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After his certificate ha completely filled in by the funeral director, page	Certificate:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	ot be	ury - At home, farm, s		Yes 2 No 28f.	Location (Street City or Town, Sta	and Number or Rural	Route Number,
Õ	spital o nours of neral Di y filled ir		29a. Certifier 1 Certifying F	Physician: To the best of	my knowledge, deat	h occurred at the tim	e, date and place, and d	lue to the cause(s	and manner as state	ed.
	the Ho thin 24 I the Fu	Medical	(Check 2 Medical Ex	aminer: On the basis of e lurse Practitioner: To th	xamination and/or inv	estigation, in my opini ge, death occurred at	on, death occurred at the time, date and place,	time, date and pla and due to the cau	ace, and due to the cau use(s) and manner as s	se(s) and manner stated. tated.
	한 60		200. Signature and three certifier			DO (	37398(	29d. I	Date signed (Month, E	yay, Year)
			30. Name and address of person wi	R Zwa	eath (Item 23a) (Type	S Garr	ett Avo	laP	lata M	D 20646
	Sta Registra		31. Date filed (Month, Day, Year)  OCT 23		ar's Signature	park	,,,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33942 State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 1430 Dung Sinh Chau 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Months Hours Director 225-51-8047 1 X M 2 □ F 76 Yrs. 11/15/1935 Vietnam r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maruland Montgomeru Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 13207 Tamarack Road 20904 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 X No Specify: 3 Divorced Asian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Factory Potteru Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matthew Chau - Son 13207 Tamarack Road, Silver Spring, Maryland 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🛱 Burial 2 □ Cremation 3 □ Removal from State Important: any injury once, Parklawn Mem. Park Rockville, Maryland 4 Donation 5 Other (Specify) 11/08/2012 Signature of Funeral Service Licenses <sup>22. Name and Address of Facility</sup> Hines-Rinaldi Funeral Home, Inc 11800 New Hampshire Ave., Silver Spring, MD 20904 MO1564 KATAI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Cardiac Arrest Medical Due to (or as a consequence of) Examiner Advanced Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death To the Hospital or Attentions.

Within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 \( \subseteq \text{Nursing Home} \) 5 \( \subseteq \text{Residence} \) 6 \( \subseteq \text{Other} \) (Specify) ပ္ 1 ☐ Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in manner as a stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated nd title of certifier M.D. D66249 October 18, 2012 and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan Duran. M.D. 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 2 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ UIZHEN 2:10 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Huattsville Prince George's NMS Healthcare St. Thomas More Medical Complex 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1891/14/1931 219-41-9558 China **Director** 81 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8017 Lakenheath Way 20854 u.s.A. I Hygiene. other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. Asian 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Lubai Chen Yu Xiang Qian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8017 Lakenheath Way, Potomac, Maryland 20854 Xin-Xing Gu - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) injury or Parklawn Mem. Park Rockville, Maryland 10/25/2012 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center MeWarker 1232 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) 1 Yes 2. 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2/ No Division of Vital Records, 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performe 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred n medical To Be 26. Place of Death (Check only one) 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending Natural work? 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) casalle 11 ocd, Nigattsoille Maryland RUSEKT MCNEIL 4922 31. Date filed (Month, Day, Year) **QCT 2 3 2012** State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Month 3 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month ( Physician/ 5HAM rrunc Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Minori Itumor If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 1 M 2 X F Country) **Director** Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🗖 No timor timox ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral US A Ever in U.S 11. Marital Status Was Decedent Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 0 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify B "natural", 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) IN fant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Department of Health and Ment. Important: If item 27 is marken any injury or All 1 KNOWN 19a. Informant's Name/Relationship (Type, Print) mother Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) cemetery, crematory or other place, - ASAton 21. Signature of Funeral Service Licenses Name and Address of Facility Bradle 34 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami -transit that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Year Day Pregnant at time of death 1 ☐ Yes 2 ☑ 9 ☐ Unknown Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No page 2 No 1 Tes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital 2 40 မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural injury 5 Pending after death.

Director: Aft 1 Yes 2 No ☐ Accident Investigation M the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined To the Hospital within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) + ASOCIS SADO 31. Date filed (Month, Day, Year) State 2 3 2012 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CRAVER Month Year GLE : 20 P M OLTUBER 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TRANSITIONS CARE HEALTH SYKESVILLE CARROLL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last hirthday) **Funeral** 8. Date of Birth (Month, Day, 1 🕅 M 2 🗆 F Months Days Min 213-40-3321 **Director** Feb Usual Residence of Decedent 28a-f show 10b. County 10a. State the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Carrol1 Woodbine 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 7255 S. Woodbine Road 21797 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or 1 Never Married 2 Married δ 72 hours after 1 ☐ Yes 2 🗓 No Specify: Completed 3 Widowed 4 X Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) unk weigh station injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Craver Grace Wiles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6718 Willis Lane Frederick MD 21702 19a. Informant's Name/Relationship (Type, Print) Janet Hewitt/niece 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) in state <sup>2</sup>State<sup>ad</sup> Address of Facility</sup>Board 655 W. Baltimore Street Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, one art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ AIZHEIMERS DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of). burial-transit that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Dav Year Pregnant at time of death 1 Yes 2 L 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 🗌 Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pendina work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accider
3 Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination allows investigation, it may opinion, south a state and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number D57722

Registrar DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

**Division of Vital** 

1838 GREENE TREE ROAP # 300 PILLES VILLE MD 21208

2012

M-P.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LEONADO RICHARDSON M.P.

OCT

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

		1- For State Registrar State of Maryland / Department Certifica	ent of Health and Mental I ate of Death	,,,	2012	2 3394
Physic ledical Exam		Decedent's Name (First, Middle,Last)		2. Date of Dea		3. Time of Death
redicai Exam ∞	ine	Melvin L. Carter  4a. Facility Name (if not institution, give street and number)		Month October 1	Day Year , 2012	1310 hrs
		Sinai Hospital	4b. City, Town, or Location of Dea Baltimore	th	4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	77		th (MM/DD/YYYY) 9. Bir	
Director		Usual Residence of Decedent	Yrs. Months Days Hours M	Jan 27		untry) unk
v any		10a. State 10b. County 10c. City, Town of	r Location			10d Inside City Limits
Aaryland 28a-f show Lat once,	ţ	MD Baltim	ore			1 X Yes 2 No
he Mar or 28a	Director	10e. Street and Number 4511 Roland Avenue	10f. Zip Code 21210	1	0g. Citizen of What Cou USA	ntry?
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland to felled has an Anneal Hygien with the Maryland with fitten 27 is marked other than "natural", or items 23a or 28a-f she uris. If item 27 is marked other than "natural", or items 23a or 28a-f she uris. If the Medical Examiner must be notified at once			13. Was Decedent of Hispanic Origin? (	Specify Yes or No		can Indian, Black,
er deat , or ite	Funeral		If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	White, etc.	
hours aft "natural" Examine	d by	or Dates:	1 Yes 2 X No specify: ecodent's Usual Occupation (Give kind of	work done	-1	ack
36 thin 72 ho te. than "ns edical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	uring most of working life. DO NOT use re	etired)	Tob. Nind of Businessin	industry unix
5-0036 iled within 72 Hygiene. I other than the Medical	mo	unk unk 17. Father's Name (First, Middle, Last)	1 19 Mother's No.	o /First Middle 1		
21215-0036 21215-0036 buld be filed within 7 I Mental Hygiene. marked other than	Be		unk 18.Mother's Nam	ne (First, Middle, M	Maiden Surname)	unk
D 27 should and Me 7 is ma	70		Mailing Address (Street and Number or			Zip Code)
e, M and 2 Health item 2'		20a. Method of Disposition 20b. Place of	00 W. Baltimore St	reet Bal	timore, MD 20c. Location - City or	21223
Baltimore, MD 2: pernit. Pages   and 2 should Department of Health and M Important: If item 27 is not injury or other traumatic e		1 Burial 2 Cremation 3 Removal from State cremator 4 Donation 5 X Other Specify: in state	y or other place)	Date	200. Education - City of	TOWIT, State
Salti ermit. epartm nporta		21. Signature of Eugeral Spriced Ligarity 11 State  Director	25 tented Addrest of Fry lity Boa	rd 655 W	. Baltimore	Street
Physician	,	23a. Aart I. Enter the disease, or complications that caused the death. Do not	Baltimore, MD 21	201		
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease a Multiple Injuries	enter the mode of dying, such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
Lammer		or condition resulting in death)  Due to (or as a consequence of):				
	ner	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest  Due to (or as a consequence of):				
760, icate be executed physician and the burial - transit		d.				
60, ate be en hysician	Medical	UNPENDED AMENDED  IF FEMALE: 23c If yes, pulsome of prepagative.				
687 ertifica ding pl		23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregn.	ancy	23d. Date of delivery Month D	ay Year
Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	Physician/	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown	Other (Specify)			
P.O. Be s that the de gned by the e detached fi	by P	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I	23e. Did tot	pacco use contribute to t	ne cause of death?
ords, P.C					2 No 3 Proba	
Records, The law require ficate has been si	Completed			24a. Was a autops perform	y prior to co	opsy findings available impletion of cause of
tal Rectian: The certificate ector, page		25. Was case referred to medical	26 Place of Death (Check	1 <b>✓</b> Yes 2		2 No
of Vital  ig Physician: ther this certineral director	To Be	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outp	Other		Residence 6 Other:	
Division of Vital P Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifi		27. Manner of Death       28a. Date of Injury       28b. Tin         1 Natural       5 Pending       Oct 1, 2012         1 Natural       5 Pending       1220 h	ne of Injury 28c. Injury at Work?	28d. Describe he Fall from heigh	ow injury occurred	
Division tal or Attendir rs after death. al Director: A	ficat	2 Accident Investigation	Tes 2 No		reet and Number or Rura	- Deuts North Cit
Div spital o	Certification:	4 Homicide determined (Specify) Single Family Hor		or Town, Sta	ate) venue, Baltimore, MD	
a i i i i	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or investigation.	occurred at the time, date and place, and estigation, in my opinion, death occurred a	I due to the cause at the time, date a	(s) and manner as state	d. cause(s)
To Con	Me	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Mont	
		Caroc Haclain	O.C.M.E.		October 2, 2012	
		<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Carol H. Allan, MD Assistant Medical Examiner 900</li> </ol>	W. Baltimore Street, Baltimore	MD 21223		
		31 Date filed (Month Dec. Vere)	hare			
Regist	Eli	OCT 2 3 2012 Burn D. A.	a comment			

12-07430 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Donald Calloway State of Maryland / Department of Health and Mental Hygiene 2012 3394 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death **Medical Examiner** 1221 hrs Donald Calloway October 1, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1616 N. Caroline Street **Baltimore** 5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** unk Foreign Country) Months Davs Hours Director 68 1X M 2 F Yrs July 19. 1944 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD 1 Yes 2 No Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Montal Hygiene, a satural; or items 73s or 28s-f she or other traumaite event, the Modical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1616 M. Caroline Street 21205 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces White, etc. 1 Never Married unk 1 Yes 3 Widowed 1 Yes 2 X No specify: 4 Divorced If Yes, Give Year black ੬ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work doneUN K 16b. Kind of Business/Industry unk Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be 9a. Informant's Name/Relationship (Type. Print )
Amber Ballanger— friend 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 3624 Chesterfield Avenue 21213 2 **Baltimore** Street Baltimore, O.C.M.E. 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition 20c. Location - City or Town, State ltimore, crematory or other place) Burial 2 Cremation 3 Removal from State Department of Donation 5 X Other specify: in 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval List only one cause on each line. Between Onset and /Medical a. Atherosclerotic Cardiovascular Disease complicating Chronic Alcohol Abuse Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last has been signed by the attending pbysician and 2 should be detached for use as the burial - transit Hospital or Attending Physician: The law requires that the death certificate be executed hysician/Medical X AMENDED 19a-b. UNPENDED per inf g9351/24/13 trt Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 立 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? page Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 🗸 Other: Scene this ER/Outpatient 3 DOA 1 Yes 28a. Date of Injury (Month, Day,Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: A 5 Pending 1 Yes 2 No filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Certific 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

and manner stated

32. Registrar's Signature

Turrell, me 30. Name and address of person who completed cause of death (Item 23a)

29b, Signature and title of certifie

31. Date filed (Month, Day, Year)

Pamela E. Southall, MD

29d. Date signed (Month, Day Year)

October 2, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** ONSTANCE 20/2 october 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Touson MD 21204
If Under 1 Year | If Under 24 Hrs. | 8. Dai 7001 <u>Baltimore</u> NCHAR 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 128-22-0588 Min. 1□M 2₽F Director May 31, 1925 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 No Directo |Maryland | Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21204 USA 8112 Bellona Avenue Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Healthcare Dietitian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ျှ Montalbano Joseph Sala Gaetana 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 217 Trappe Road, Dundalk, MD 21222 Gaetana Patricia Welsh/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 10/23/12 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Dulaney Valley Memorial Gardens Timonium, Maryland Signature of uneral Service Licensee Bryan W. Clary 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 23a. Part1. Enter the disease, or complication, that can sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart ailure. List only one caus on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease of condition nearth) taulur Diastolic Wee **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed the burial-tra Due to (or as a consequence of): attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sign be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No page certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: r death. 24 hours after death Funeral Director: filled in by the

completely within 2. Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mD ADDO 8415

and manner stated.

BELLONA LANE #216,

29d. Date signed (Month, Day, Year)

(Month, Day, Year)
OCT 2 3 2012

(Check only

29b. Signature and title of certifier

one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month ( 0 Physician/ EULIS 10.38 A M 20 12 4a. Facility Name (if not institution, give street and number) Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Regional PRINCE GEORGES Birthplace (State or Foreign Country) 6 Sex If Under 24 Hrs. 8. Date of Birth 5. Social Security Number **Funeral** Hours Months (Month, Day, 238-64-3934 1 🛛 M 2 🗆 F Director March 20,1942 North Carolina Yrs 70 Usual Residence of Deceder permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show an injury or other traumatic event; the Medical Examinar months. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 🏋 Yes 2 □ No Prince George's Upper Marlboro MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral USA 20774 13006 Mears Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces?

1 Yes 2 No Black White etc. ò 1 Never Married 2 X Married 1 Yes 2 X No Specify. If Yes, Give Year or Dates Specify: Black Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private Truck Driver 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Beulah Johnson William Clanton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13006 Mears Court Upper Marlboro, MD 20770 Catherine Clanton/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 10-24-2012 Clinton, Maryland 22. Name and Address of Facility J. B. Jenkins Funeral Home, Inc. 21. Signa r une 7474 Landover Road, Hyattsville, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dimamia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Control of the contro in the past 12 months?
1 Yes 2 No Month Year ate has been signed by the atterpage 2 should be detached for Day Pregnant at time of death 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? perform 1 Yes 2 No this certificate ie Hospin... .in 24 hours after death. the Funeral Director: After this certificate the Funeral director, p₹ 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 only one) 29b. Signature and title of certifier 29c. License number 10, 18. 2012 D68782 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Adeder 31. Date filed (Month, Day Jear) 2. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Chih-Ying Chao October 20. Ž012 5:29 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 125-64-3248 Director 1 □ M 2 🕅 F 91 September 15, 1921 China Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Gaithersburg 1 🗆 Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 8109 Crabapple Lane 20879 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2 💆 No Specify: Completed 3 X Widowed 4 Divorced Specify: Asian Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home is marked other Be pelij eq 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Not Available Not Available t. Page 1 and 2 should by dment of Health and Mer dant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) / Daughter Cora Yen 13424 Rippling Brook Drive, Silver Spring, MD 20906 Important: If item any Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 26, 2012 Silver Spring, Maryland 21. Signature of Fungral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland Markette Onnut M01305 20850-2805 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner Congestive Sequentially list conditions, if any leading to immediate cause. Enter Underlying Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury perico attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 pronths?
1 Yes 2 No Day Pregnant at time of death ate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Yes ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending (Month, Day, Year) work? 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examine. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Number Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier D0061386 30. Name and address of p rson who completed cause of death (Item 23a) (Type, Print) 9901 medical Jonia John 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

12-07767 Ronald Noland C	arte			<b>Print in Bl</b> Maryland							-	0.17	2 2225
		I- For State Registrar			Cert	ificate o	of Deat	th		R 2. Date of Dea	eg. No.		2 3395
Physicia Medical Examir		1. Decedent's Name (First, I Ronald Nol	_							Month October 1	Day Y 3, 2012	ear	3. Time of Death 1410 hrs
		4a. Facility Name (if not inst 5223 Edgewood R		reet and number)			1	Town, or Lo	ocation of Death		Prince	y of Death George'	
Funeral Director		5. Social Security Number unk	6. Sex	7. Ag	e (In yrs. las 76			der 1 Year hs Days	If Under 24Hrs Hours Min		0/1936	Foreign	oplace (State or ntry) WashDC
<b>b</b>	ŀ	Usual Residence of Deceder	nt			Town or Loc				0372	3,1330		10d. Inside City Limits
and show any	ь	MD	•	eorges		lege		ς					1 Yes 2 No
	Director	10e. Street and Number 5223 Edgew	ood Ro	oad			10f. Zip	2074	.1	1	0g. Citizen of V	What Count	try?
ath with icms 23	Funeral	11. Marital Status 1 Never Married 2	Married 12	2. Was Decedent					anic Origin? ( Sp Mexican, Puerto	pecify Yes or No Rican, etc.)		ce - Americ nite, etc.	an Indian, Black,
s after de	by Fu		Divorced or	res, Give Year Dates:	X No	1 [		No No	specify:	work done	Specify	у:	hite
6 172 hour: an "natu	leted	15. Decedent's Education  Elementary/Secondary (0  1 2		College (1-4 or		during	most of wo	orking life. E	NOT use ret	ired)	Aut		lausily
5-0036 iled within 72 Hygiene. I other than the Medical	Completed	17. Father's Name (First, Mi	ddle, Last)	<u> </u>					.Mother's Name	e (First, Middle,	Maiden Surnan	ne)	
2121; Mental Fill marked	Be	Unk 19a. Informant's Name/Rela	tionship (Type	Print )		19b. Maili	ing Address	s (Street a	Unk and Number or	Rural Route Nur	nber, City or To	own, State,	Zip Code)
MD : id 2 shoulth and I m 27 is summatic	-	Rhonda Br		Daughte						ve Cla	rksvil		D 21029
nore, ages 1 ar nt of Hez nt: If ite		20a. Method of Disposition 1 Burial 2 X Crem		Removal from St	ate At	ace of Disp ematory or lant	other place LC C1	cem					nie MD
Baltimore, permit. Pages I as Department of He Important: If ite	ŀ	4 Donation 5 Oth 21. Signature of Funeral Se	rvice Licensee	nl	,								Fun Serv
Physician	$\dashv$	23a. Part I. Enter the diseas	e, or complica		the death. I								nover MD Approximate Interval Between Onset and
/Medical Examiner	١	Immediate Cause (Final dis or condition resulting in dea	ease a. Gu	inshot Wound							-		Death
	Į.	Sequentially list conditions, if any, leading to immediate	b	e to (or as a cons	equence of)	:							
	Examiner	cause. Enter Underlying Cause. (Disease or injury that initial events resulting in death). L	ted C.	e to (or as a cons	equence of)	:							
executed an and al - transi	ca	UNPENDED	d	MENDED 28a	per n	ne,g93	35 1-8	8-13 s	Sm .				
68760, certificate be nding physicise as the burise se as the burise		IF FEMALE: 23b. Was decedent pregnan		23c. If yes, outcom		ancy			Ectopic pregna	ancy	23d, Date Month	of delivery	ay Year
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and theretal director, page 2 should be detached for use as the burial - transit	Physiciar	past 12 months?  1 Yes 2 No 9	l Halenaum	Pregnant at	time of dea	4b	Fetal death Other (Spe			unity	I I I I I I I I I I I I I I I I I I I		.,
.O. B hat the deed by the	by Phy	Part II. Other significant co		ntributing to deat	h but not res	sulting in the	e underlying	g cause giv	en in Part I.			_	ne cause of death?
ds, P. requires the seen signe could be de										24a. Was	an 24b	. Were auto	opsy findings available
of Vital Records, ig Physician: The law require this certificate has been sineral director, page 2 should be	Completed	_							-	autor perfo 1 <b>✓</b> Yes	rmed?	death?	empletion of cause of
/ital F sician: 'sician: is certifu	o Be C	25. Was case referred to me examiner?  1 ✓ Yes 2 No	Hos	pital: 1 Inpatie	ent 2 E	ER/Outpatie			f Death (Check ther Nursi	only one)	Residence 6	Other:	Scene
sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be reads.  ctor: After this certificate has been signed by the attending physici by the finneral director, page 2 should be detached for use as the burn	ä	27. Manner of Death	Pending	28a. Date of Inju		28b. Time o	of Injury	28c. Injury	at Work? s 2 ✓ No	28d. Describe Subject sho	how injury occu ot self	лгед	
= 5 p = Z	ificati	2 Accident 3 Suicide 6	Investigation Could not be	<del>Jan 13, 2012</del> 28e. Place of Ir		1336 hrs me, farm, st	reet, factory			28f. Location ( or Town, S		nber or Rur	al Route Number, City
Di the Hospital hin 24 hours a the Funeral I	al Certifi	4 Homicide  29a. Certifier (Check only 1 Certifyi	determined ng Physician:	(Specify) Sir				e time, date	and place, and	5223 Edgewo	ood Road , Co		
To the within 2 To the complet	Medical	one) 2 Medica 29b. Signature and title of c	an	n the basis of exa nd manner stated.	mination an	d/or investig		y opinion, o		at the time, date			cause(s)  th, Day, Year)
		Lun (	1					O.C.M			October		
5		30. Name and address of po		npleted cause of d			ore Stre	et, Baltir	nore, MD 2	1223			
St Regist	ate	31. Date filed (Month, Pay.)	23 201	2 32. Fegistra									

				Please T	ype or Pr AMEND I State of M	int in EM#8	Black II	ndelik G933 artme	ole Ink	7. Ensure	All C	opies	Are Legib	ole.		
			For State Registrar			rai yrai			te of D		TVICITI		g. No. 2	12	3395	2
	Physicia Medi		1. Decedent's Name (First	1 De	nise	De	nnis				ď	ate of Death Johth	17,20	12	3. Time of Death	Λ
2	Examir	ner		eens	pring A	Apo	1. 201		Balt	location of Deat			4c. County of			
1-1	Funeral Director		5. Social Security Number 218-46-98 L Usual Residence of Deci		M 2 M F	65 (In yrs. 1	ast birthday) Yrs.	Months	er 1 Year Days	If Under 24 Hrs Hours Min.		ate of Birth Month, Day, Y	0-7-1947 : <del>2012-</del>	9. Birthpla Country	ce (State or Foreig MD	n
/-	e Meryland r 28e-f ehov	Director	10a. State 10b.	County		10c. Cit	altic	cation	e_			, ,		10d	I. Inside City Limits	
10	death with the Meryland iteme 23a or 28e-f eho	Funeral Di	10e. Street and Number 6310 Gree	nsprin	ng Aver	Apt.	201	10f. Z	ip Code	215		10	g. Citizen of Wh	at Country	l3	
∩, S 036		ģ	11. Marital Status  1  Never Married 2 3  Widowed 4	☐ Married	2: Vas Decedent Armed Forces? 1  Yes 2 If Yes, Give Year or Dates.	Ever in U.S			edent of His ecify Cubar 2 No	spanic Origin? (S n, Mexican, Puer Specify:	pecify Ye to Rican	es or No- , etc.)	14. Race - Black, Specify:	American White, etc		
Jenn' 21215-0036	vithin 72 ho liene, ir then "ne ir e we sig	Completed	(Specify on Elementary Secondary			5+)		kind of w		ation uring most of wo	orking	1	Hind of Busi Hate Mary	lan	stry	
yland	<b>g</b> de de de de de de de de de de de de de	To Be	17. Father's Name (First, M	_ 11	well					18 Mother's Na	me (Firs	ΙΛ		ide		
NA C	1 and 2 should be f Haelth end Men Item 27 ie marke other traumatic	- 3	Gregory F	1. Bul	Print) (So	JC_	11117	·Cu	ss (Street a	nd Number of Ru	ural Rout		alto,		21228	'
SC/C altimore,	e = = 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cre 4 ☐ Donation 5 ☐	mation 3  Re		186 U	icc c	sition///a	TO PE	10/2		12	oc. Location'- C	ty or Towr	, State	
$\mathcal{Q}_{\frac{1}{2}}$	permit. Peg Dapertmant Importent: eny injury o		21. Signature of Funeral S	ervice Licensee	Green	٩	5	No.	and Abdress	s (Tacill® (	ene	e Tun	eral S	eri 229	ces	
	Physician/		23a. Part 1. Ent the dise shock, or heart failur Immediate Cause (Final disease or condition	ease, or complic e. List only one	ations that cause cause on each lin	d the deat	h. Do not ente	er the mo	de of cying	, such as cardia	c or resp	iratory arrest	.,	ln In	pproximate nterval Between onset and Death	1
	Medical Examiner		resulting in death)	. <b>f</b> .	Due to (or as	a consequ	uence of);	>(d	then	oschi	2/10,	how	HOILE	9/7	5m9M	15
	s axecuted len and urlal-transit	Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events	te d c.	Due to (or as									7		
092	cete be axe physicien a s the burlai-	=	resulting in death) Last	L d.	Due to (or as	a consequ	uence of):									
. Box 68760	To the Hospital or Attending Physicien: The lew requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending physici completaly filled in by the funeral director, page 2 should be deteched for use as the bu	Completed by Physiclan/Medica	IF FEMALE: 23b. Was decedent pregint the past 12 morths 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ant 1	c. If yes, outcome 1  Live Birth 4  Pregnant a	2 Feta	aldeath 3	Ectopic Other (s		<b>y</b>			23d. Date of Month			
s, P.O.	fres thet the signed by Id be dete	d by Pi	Part II. Other significant of	conditions contr	ributing to death t	but not res	sulting in the u	nderlying	g cause give	en in Part I.	2		cco use contribu		cause of death?	n
Division of Vital Records,	ie lew requ e hes beer age 2 shou	omplete	- Ay/s	esty	1dom	a					2	24a. Was an autopsy perform	prid ed? dea	or to comp th?	findings available letion of cause of	
<u> </u>	sien: Th ertificet ector, pe	BeC	25. Was case referred to n examiner?						26. Pla	ce of Death (Che		I ☐ Yes 2	No 1 □	Yes 2	□ No	
Ž	Physic r this co	<u>유</u>	1 Yes Z No	Hos	spital: 1  lnpat 28a. Date of inju		ER/Outpatier		Othe 28c. Injury	4 L Nursing I			ce 6 Other (	Specify)		
9	ending seth. or: Afte the fund	ficate	2 Accident	Pending Investigation	(Month, Da	ıy, Year)	injury	М	work?	Yes 2 No	20u. b	rescribe now	injury occurred			
Divisi	oital or Att urs after du rei Directo	al Certificate:	4  Homicide	Could not be determined	28e. Place of Inj building, et	c. (Specify	)				С	ity or Town,				
	ne Hospin 24 hospin 24 hospin 24 hospin pletaly f	Medical	(Check 2 ⊔ Me	edical Examiner	ian: To the best of r: On the basis of e Practitioner: To th	examination	n and/or invest	tigation, ir	my opinior	n, death occurred	at the tin	ne, date and	place, and due to	the cause	(s) and manner stat	ed.
	With Common of the common of t		29b. Signature and title of	certifier (	W.	2		29	c. License	number 488	)	290	Date signed (A	nonth, Day	( Year)	
10			30. Name and address of	1 / 100	npleted cause of a	death (Item	23a) (Type, F	rint)	t.Si	ite 2	)z,	Bal	timos	m	0 2/2/	7
/	Sta Registr		31. Date filed (Month, Day, OCT 2 3 2		32. Registr	r's Signa	are and					<del></del>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Manth Physician/ RIENE Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Augsburg Lutheran Home Baltimore Lochearn 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Davs Hours Min 216-20-7493 **Director** 1 □ M 2 🔼 F 89 Yrs Oct. 2, 1923 Maryland Usual Residence of Decede 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Funeral Director 1 Yes 2 X No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a 8 Drawbridge Court 21228 USA Was Deceus. Armed Forces? ✓ Ves 2 🔀 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. White ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 Arlene Dutra Carl Horn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 Drawbridge Court; Catonsville, MD 21228 19a. Informant's Name/Relationship (Type, Print) Mary C. Drager Daughter item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State o = 10 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Loudon Park Cemetery 10/25/12 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) <sup>22</sup> Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Signature of Funeral Service Lice MD 21228 1630 Edmondson Avenue; Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final ATHEROSCLEROTIC FREBROVASCIL Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day Pregnant at time of death or: After this certificate has been signed by the a the funeral director, page 2 should be detached Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ LILCET 1 Yes 2 No 3 Probably 4 Unknown Records, Completed Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Marner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After it ☐ Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3

Registrar
DHMH 17 Rev 06-2011

State

1 ASN EEM

31. Date filed (Month, Da

m)

1521

WINGS

P.D

mD

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAKOTANI,

12-07050 Brigette Doherty Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

rigette Donerty		1- For State	laryland / Depan Certi	ment of F ficate of E			201 eg. No.	2 3395
Physici		Registrar  1. Decedent's Name (First, Middle,Last)				2. Date of Dea	th	3. Time of Death
ledical Exami	ner	Brigette Doherty  4a. Facility Name (if not institution, give stree	A	145	Oit T		er 18, 2012	1400 hrs
		18900 Treebranch Terrace	t and number)		City, Town, or Location of Germantown	or Death	4c. County of Deat  Montgomery	n
Funeral Director		5. Social Security Number unk 6. Sex	7. Age (In yrs. last		If Under 1 Year If Under 1 Months Days Hours	Min.	th (MM/DD/YYYY) 9. Bin Forei	thplace (State or unk gn puntry)
any		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
	F	MD Montgon	nery (	Germanto	own			1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 18900 Treebranch Te	errace	1	0f. Zip Code 20874	1	0g. Citizen of What Cou USA	ntry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Funeral		Vas Decedent Ever in U.S. umed Forces?  Yes 2 No U.D.	If Yes,	ecedent of Hispanic Orio specify Cuban, Mexican			ican Indian, Black,
irs after d	百	3 Widowed 4 Divorced If Yes, or Dat  15. Decedent's Education (Specify only high	Give Year	1 Y	es 2 X No specify:		Specify: wh	ite
5-0036 led within 72 hours a Hygiene. sother than "natura the Medical Exami	pleted		ollege (1-4 or 5+)	during most	of working life, DO NOT	use retired) UTIK		unk
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medical	3e Comple	17. Father's Name (First, Middle, Last)			unk 18.Mother	's Name (First, Middle, I	Maiden Surname)	unk
2121, hould be fil ad Mental H is marked atic event, t	To B	19a. Informant's Name/Relationship (Type, Pr	rint )		ddress (Street and Num			e, Zip Code)
e, MD 2 1 and 2 shoul Health and Iv item 27 is n		O.C.M.E.  20a. Method of Disposition	20b. Pla		Baltimore n (Name of cemetery,	Street Balt	imore, MD  20c. Location - City or	Z1223 Town, State
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		1 Burial 2 Cremation 3 Re		matory or other				
Balt permit. Departu Import injury		21. Signal of Funeral Service Censee  Ronald S	Viterrer	Stat	e and Address of Facility te Anatomy l timore, MD	, Board 655 W 21201	. Baltimore	Street
Physician /Medical	1	23a. Part I. Enter the disease, or completion failure. List only one cause on each line			mode of dying, such as c	ardiac or respiratory arro	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		401	<pre>ciple Injurie (or as a consequence of):</pre>	28				Deati
	<u>_</u>	Sequentially list conditions, if any, leading to immediate b. Due to	(or as a consequence of):					
	Examiner	cause. Enter Underlying Cause	(or as a consequence of):					
ecuted and transit		d	22 11	27 20-	<b>F</b>	022 10 27 1	10	
60, ate be exe hysician e burial	edic		NDED 23a, pt.II		-ı,per me,g	932 10-24-1		
687 ertifica ding pl	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnar Live birth Pregnant at time of death	2 Fetal	death 3 Ectopic	pregnancy	23d. Date of deliver	V Day Year
BOX the death or y the attended for us	hys	Yes 2 No 9 Unknown 9  Part II. Other significant conditions contril	Unknown	Iting in the und	orlying squee given in Ba	at 1 23a Did to	bacco use contribute to	the cause of death?
P.O.	ē	Osteoporosis, Scol		itting in the dilu	arrying cause givernin r a		3 No 3 Prol	
of Vital Records, og Physician: The law requir. Wher this certificate has been smeral director, page 2 should law of the page 2 should be a should be	Completed					24a. Was a autop perfor		topsy findings available completion of cause of
		25. Was case referred to medical			26.Place of Death	1 Yes	2 No 1 Y	es 2 No
Vita ysicial his cer directe	To Be	examiner? 1 ✓ Yes 2 No	1 Inpatient 2 EF	∛Outpatient 3	Other		Residence 6 🗸 Other	r: Scene
	Ë	27. Manner of Death	a. Date of Injury (Month, Day,Year)	Bb. Time of Injur			now injury occurred	
Division tal or Attendi rs after death. al Director: /	ertification:	2 X Accident Investigation	d 9-18-12 f Be. Place of Injury - At home	d 14:00			Street and Number or Ru	ral Poute Number City
	ertif	Suicide Could not be	Specify) Single I				tate) <b>Unknown</b>	na Noute Number, City
the Hohin 24 the Fu	edical C	one) 2 Medical Examiner: On the	the best of my knowledge, e basis of examination and/		·		' '	
To with	Me	29b. Signature and title of certifier	anner stated.		29c. License number		29d. Date signed (Mo.	nth, Day, Year)
		Alle Bull.	red as use of death //hours as	(a)	O.C.M.E.	<del></del>	September 19, 2	012
			nt Medical Examiner	•	Baltimore Street, Ba	altimore, MD 2122	23	
St Regist		31. Date filed (Month, Day, Year)  OCT 2.3 2012	32. Registrar's Signature	bar	W.			

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006 Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

ı	For State	e Type or Print in State of Marylan	nd / Departme			ygiene	
ian/ lical	Registrar  1. Decedent's Name (First, Middle, L	DUNCA	n)	te of Death	2. Date of D Month	Day.	3. Time of Death Year 2012 12:30 PM
iner	4a Pacility Name (if not institution, graph Marcus) 5. Social Security Number  202-10-9740	Sex 7. Age (In yrs. 1	ast birthday) Il Und Month	y, Town or Location of D	Burn	P An	
	Usual Residence of Decedent  10a. State  10b. County		ty, Town or Location		January	8, 1919	Arizona  10d. Inside City Limits
Funeral Director	Maryland Anne A	Arundel		enton Zip Code		10g. Citizen of	1 ☐ Yes 2 🕵 N What Country?
d by	1192 Hammond La  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces?	I	21113 edent of Hispanic Origin' ecify Cuban, Mexican, P 1 No Specify: At	·	)- 14. Rad	ted States De - American Indian, ck, White, etc. White
To Be Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education	life. DO NOT L	ork done during most of	working	N	ational
To Be (	17. Father's Name (First, Middle, Las Joseph Skellcho			18. Mother's	Name (First, Middle	e, Maiden Surnam lvas	
	19a. Informant's Name/Relationship Henry D. Duncan 20a. Method of Disposition	, Jr./Husband	1192 Ham	ss (Street and Number on nond Lane, (	Odenton, 1	Maryland	
	1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	Removal from State cify)	West Ar Crema	under Oct	tober 20, 2012	Odento	n, Maryland ry, P.A. ryland 21113
cal Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	e renal	failur	•		Few day.
by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  Ne 9  Unknown	23c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of 6 9 Unknown	al death 3 🗌 Ectopi				ate of delivery onth Day Year
ed by Ph	Part II. Other significant conditions	contributing to death but not res	sulting in the underlyin	g cause given in Part I.			tribute to the cause of death?
Completed					_ perf	opsy formed?	Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	ER/Outpatient 3	26. Place of Death (	Check only one)	sidence 6 🗆 Oth	er (Specify)
Certificate: 7	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could no	he	28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occurr	red
	4 Homicide determine  29a. Certifier 1 Certifying Pl	nysician: To the best of my know	/) ledge, death occurred	at the time, date and pla	City or To	cause(s) and man	er or Rural Route Number,
Medical	(Check 2 Medical Exa	miner: On the basis of examination urse Practitioner: To the best of r	n and/or investigation, my knowledge, death o	n my opinion, death occur courred at the time, date a gc. License number	rred at the time, date and place, and due to	and place, and du the cause(s) and r 29d. Date signe	e to the cause(s) and manner stat manner as stated. d (Month, Day, Year)
ate	30. Name and address of person wh	o completed cause of death (item  1501 505 7)  32, Registrar's Signa	n 23a) (Type, Print)	Drive (	Hen Bur	we M	0 2016)

12-07910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

villiam Dyer		State of Maryland / Department of Heal  1- For State Certificate of Deat  Registrar	, ,	Reg. No. 2012 33	95
Physici	an/	Decedent's Name (First, Middle,Last)	2. Date of D	Death 3. Time of Dear	
Medical Exami	ner	William Francis Dyer, 51.	October	r 18, 2012 2140 hrs	
hime			Town, or Location of Death icum Heights	4c. County of Death Anne Arundel	
Funeral				Birth(MM/DD/YYYY) 9. Birthplace (State or	г
Director		216-60-5652 1XM 2F 61 Yrs. Month		11/1951 Foreign Country) PA	
iny		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City	y Limits
nd show a	<u> </u>	MD Anne Arundel Co. Linthicum Heig	thts	1 Yes 2	X No
Maryland 28a-f shov d at once.	Director	10e. Street and Number 10f. Zip		10g. Citizen of What Country?	
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once			21090	United States	
eath wi	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. 13. Was Decedent In U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 19. Was Decedent Ever	ent of Hispanic Origin? (Specify Yes or fy Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black White, etc.	k,
	by Fu	3 Widowed 4 A Divorced in res, Give rear 1 Yes 2	X No specify:	Specify: White	
hours a			Occupation (Give kind of work done rking life. DO NOT use retired)	16b. Kind of Business/Industry	
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  12 yrs. Machini	-	Popor Compone	
5-00 iled with Hygiene Jother 1	Com	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle	Paper Company	
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	William Francis Dyer	Jacqueline N		
D 21 should and Me	ပို		(Street and Number or Rural Route N		
nore, MD 2121 sges 1 and 2 should be fi nt of Health and Mental 1 tt: If item 27 is marked other traumatic event,		Mrs. Shannon Dyer Reid /Daughter 117 E.  20a Method of Disposition   20b. Place of Disposition (Nan	Greenbriar Drive	York, PA 17407  20c. Location - City or Town, State	-
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and IM Important: If item 27 is m injury or other traumatic.		1 K Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: G1en Haven Mem			
altin mit. P portan				2 Glen Burnie, MD n Funeral & Crematio	
E P P E		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of	s PA: 1 2nd Ave SV	V, Glen Burnie, MD 2	1061
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line.	of dying, such as cardiac or respiratory a	arrest, shock, or heart Approximate In Between Ons	
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovas  Due to (or as a consequence of):	scular Disease	Death	
4	- [	Sequentially list conditions,  b			
	miner	if any, leading to immediate  Due to (or as a consequence of):			
=	Exam	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
ecuted and rans				10	
Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Medical	IF FEMALE: 23c If yes, outcome of prephancy	er me,g932 10-25-		
5876 rtificat ing ph as the	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnancy	23d. Date of delivery  Month Day Yea	аг
OX 6876 eath certificat e attending phi for use as the	sician/	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Spec	xify)		
D. B. t the de by the	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I. 23e. Did	tobacco use contribute to the cause of deal	th?
res tha	d b		1Y	res 2 No 3 Probably 4 ✔ Unkr	nown
Vital Records, hysician: The law require this certificate has been si director, page 2 should by	Completed		24a. Wa	s an 24b. Were autopsy findings aver	
RecC The lay	E		per	formed? death?	No
tal Recian: The certificate ector, page	Bec	25. Was case referred to medical examiner?	26.Place of Death (Check only one)		
of Viral Physical Colored Colo	유	1 Yes 2 No Inspired 1 Inpatient 2 ER/Outpatient 3 Di		Residence 6  Other: Scene e how injury occurred	
on on on the function of the f	ë	1 Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	e now injury occurred	
Division Lal or Attendia rs after death. A Director: A	ficat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory,		(Street and Number or Rural Route Number	er, City
Spital o	Certification:	4 Homicide determined (Specify)	or Town,	, State)	
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,	Medical (				
To viti	Med	and manner stated.  29b. Signature and title of certifier 29c.	. License number	29d. Date signed (Month, Day, Year)	
		Caroe Hellan	O.C.M.E.	October 19, 2012	
8	I	30. Name and address of person who completed cause of death (Item 23a)	o Street Politimers MD 2422		
St	ate	Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimor  31. Date filed (Month, Day, Year) 32. Rigistrar's Signature	- Street, Daitimore, MD 21223		
Regist	raır		<u> </u>		
DHMH 17 Rev 1/20	01	OCARE			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary J. Dolan 2012 Medical 10 11:00 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 8118 N. Boundary Road Baltimore Social Security Number If Under 1 Year Funeral 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Days Months Hours (Month, Day, Year) 03/23/1923 Country) West Virginia Director 234-32-8056 1 □ M 2 🖔 F 89 Yrs Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8118 N. Boundary Road 21222 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Page 1 and 2 should be filed within 72 hours aftenent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", ! 1 ☐ Yes 2 No Specify. 3 Widowed 4 ☐ Divorced Specify Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4 or 5+) Unkn Unkn Unkn. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Joseph Ethel Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jane Reeed / Daughter 1214 Night Hawk Drive, Christiansburg, VA 24073 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of I
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 🗆 Burial 2 🔯 Cremation 3 🗔 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 10/23/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Cance disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated quants. Examiner Due to (or as a consequence of) attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown 5 Other (specify) the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? lerodermo 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Peripheral Arterial Discese 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital ျှ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 1 Yes 2 🗌 No ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State

Baltimore, Maryland 21215-0036 Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 124 hours after death. e Funeral Director: After this certificate has been significate in by the funeral director, page 2 should I Medica Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотрівте Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 22 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deborch Gollo Do 6730 21222 Itolabind 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar DHMH 17 Rev 06-2011 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Manth Edward P. Doyle 2012 7:00 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2717 Riva Road Annapolis Anne Arundel Social Security Numbe **Funeral** 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birtl 9. Birthplace (State or Foreign Days 159-26-8036 Hours (M904/30/1933 79 **Director** 1 ☐ M 2 ☐ F Pennsylvania or 28a-f show 10a. State 10c. City, Town or Location with the Maryland Examiner must be notified at 10d. Inside City Limits Director MD Anne Arundel 1 X Yes 2 □ No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 2717 Riva Road 21421 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 and 2 should be filed within 72 hours after 1 Yes 2 No Specify "natural", 3 Widowed 4 Divorced Completed Specify White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Principal Of School Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental I Edward Doyle Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Doyle / Daughter 804 S. Lee Street, Alexandria, VA 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of . Page 1 g 20c. Location - City or Town, State Department of cemetery, crematory or other place)
Chesapeake Crematory Important: If injury ( 10/20/2012 4 Donation 5 Other (Specify) Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): physician Physician/Medical Box 68760 use as IF FEMALE: attending 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director, After this certificate I completely filled in by the funeral director, pag 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 NO မ 1 Inpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specif 27. Manner of Death Certificate: 28a. Date of injury Time of 28b. 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident Investigation 1 Yes 2 No Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signat 29d. Date signed (Month, Day, Year) and address of person, who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

8601 Veter

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 For State Certificate of Death Reg. No 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ October 17, 2012 5:00 Dillow AMAaron Medical la. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles 2174 Gothic Court Waldorf 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Ju Month 2 Day, Year 914 Tennessee 98 Director 362-05-2838 Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland Director 1 X Yes 2 No Allen Park Wayne County Michigan 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 48101 8456 Quandt Street 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Laborer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Dillow Molly Bailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2174 Gothic Ct., Waldorf, MD 20602 Sheryle Powell (Niece) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10-24-12 Huron Twp, MI Michigan Mem. Park 5 Other (Specify) 4 Donation 22 Name and Address of Facility Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310 21. Signature of Fu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Medical disease or condition resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): Exami The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the burlal-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Other (specify) Pregnant at time of death 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has performe death? 1 Yes 2 X No 1 Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medica 26. Place of Death (Check only one) filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🗓 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: iniury 1 X Natural 5 Pending 2 🗆 No Investigation 2 Accident
3 Suicide
4 Homicide Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🖸 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check 2 [] 3 [] only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin ON 0 istrar's Signature State 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 10 2012 6:42P <sup>™</sup> Physician/ Anthony John DiNicolo Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Howard Columbia Gilchrist Hospice Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Months 1 5 M 2 □ F 68 Yrs. Director 214-44-8617 Baltimore, MD 6/29/1944 Usual Residence of Deced 10d. Inside City Limits a filed within 72 hours after deeth with the Merylend tal Hygiene. of the West State of State of Show of other then "netural", or items 23e or 28e-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10a. State Director 1 Tes 2 No Halethorpe MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21227 4314 Ridge Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?

1 X Yes 2 No δ 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Computer CAD Operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Ikem 27 is marked oth any linjury or other treumetic event 2008. မှ Helen Mathai Tony DiNicolo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4314 Ridge Ave., Halethorpe, MD 21227 Beth DiNicolo / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Glen Burnie, MD 10/22/2012 Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home 21. Signature of Funeral Service Libenses 1328 Sulphur Spring Rd., Arbutus, MD 21227 ru 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ear Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine or Attending Physicien: The lew requires that the deeth certificate be executed ed by the attending physicien end deteched for use as the burlei-transif that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Day in the past 12 months? 4 Pregnant at time of death ☐ Yes 2 ☐ No 9 Unknown P. 0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To the Hospital or Attending Physician: The law requires that within 24 hours after death.

Within 24 hours after death.

The Funest Director: After this cartificate has been signed completely filed in by the funeral director, page 2 should be de 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Tes 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner? Hospital: orce Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated October 20,2012 and ted cause of geath (ftem 23a) (Type, Print) Balto Md 2120x 31. Date filed (Month, Day, Year) State Registrar

2-07781 ziah Zion Dorse	21/	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	
Liail Zioli Doise	- y	State of Maryland / Department of Health and Mental Hygiene  1-For State RegIstrar  Certificate of Death Reg. No.	112 3396
Physici Medical Exami		1. Decedent's Name (First, Middle,Last)  2. Date of Death	3. Time of Death 0441 hrs
		4a. Facility Name (if not institution, give street and number)  Harbor Hospital Center  4b. City, Town, or Location of Death  Baltimore	Death
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs, 8. Date of Birth (MM/DD/YYYY)	
Director		$186-92-6104$ $1 \times M$ $2 \subseteq F$ $1 \times S$	Foreign CountMaryland
ku w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
. ₹	_	Maryland Raltimore City	1 X Yes 2 No
farylar 28a-f.s	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What	at Country?
r death with the Maryland nr items 23a or 28a-f sho must he notified at once.			ates
th with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15. White,	American Indian, Black, etc.
ter dea			Bi-racial
ours af atural	d by	O 15 December 5 december 100 Julies:	
6 2 72 hc	lete	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)  0 0 N/A	
-003 within giene. her th	Completed	0 0 N/A N/A  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must he notified at once	Be	Jason Dorsey Anna Snowden	
<b>∑</b> 2428	P.	Anna Snowden / Mother 3623 Everett St., Baltimore, Marylan	State, Zip Code) 1d 21226
imore, Pages 1 and ment of Heal lant: If item or other tra		1 Puriol 3 VVccomption 3 Pomeral from State Crematory or other place)	City or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite		Atlantic Crematory Oct. 21,2012 Glen Bu	
Baltimo permit. Page Department o Importunt:	1	22. Name and Address of Faciliam BROSE FUNERAL HOME	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear	t Approximate Interval
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  aProbable Asphyxia  Due to (or as a consequence of):	Between Onset and Death
To a		Sequentially list conditions,  b	
	ine	if any, leading to immediate Due to (or as a consequence of):	
sit	cal Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
3760, ficate be executed g physician and s the burial - transit			00.
ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be eath. or: After this certificate has been signed by the attending physicia the funeral director, page 2 should be detached for use as the burial	Physician/Medi	IF FEMALE: 23d. Date of d 23d. Date of d	•
x 68 h certi tending use as	iciar	December 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	Day Year
Bo) ne death the att	hys	1 _ Yes 2 _ No 9 _ Unknown 9 _ Unknown	
rres that the d signed by the	Ą		
ords, w requires s been sign should be	ted	1 24a, Was an 1 24b, W	ere autopsy findings available
cor e law r e has b	Completed	autopsy pri perform <u>ed</u> ? de	or to completion of cause of ath?
of Vital Records, og Physician: The law require ther this certificate has been si meral director, page 2 should b			Yes 2 No
Vital   hysician: this certifi al director,	o Be	examiner?    Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other   Nursing Home 5   Residence 6	Other:
Ing Ph	Ë	27 Manner of Dooth 220 Date of Joiner 20th Time of Joiner 20th Jones 10th Jon	
Sior Attend death. sctor:	catic	Natural 5 Pending Fd 10-14-12 fd 00:00 am 1 Yes 2 No subject asphyxia	
Division pital or Attendio ours after death, ceral Director: A	Certification:	Suicide 6 Could not be determined (Specify) Specify Home 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Town, State) 5200 Bit 15 Brooklyn, MD	allman Ave.
Division To the Hospital or Atteno within 24 hours after death To the Funeral Director:	Medical C	1 29a. Centiler	s stated.
To To Com	Med	and manner stated,  29b. Signature and title of certifier  29c. License number  29d. Date signed	(Month, Day, Year)
		O.C.M.E. October 15,	2012
ļ		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio M.D., Ph. D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
St Regist	ate trar		
DHMH 17 Rev 1/20 OCME 2006		ORIGINAL	
JOHIL ZUUD		OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 State 5H Maryland 7 Department of Health and Mental Hygiene State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2012 SELMA DRIVER 09:55a™ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE TOWSON BALTIMORE CO. Social Security North 83 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours Director 1 🗆 M 2 🗓 F 212-28-5883 87 Yrs. Usual Residence of Decedent MAY3, 1925 VIRGINIA 28a-f shov 10a. State 10b. County be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No MARYLAND BALTIMORE **ESSEX** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1604 BROWNS ROAD 21221 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? à Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Completed 3 X Widowed 4 Divorced If Yes, Give Specify: BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If Item 27 Is marked other than ' CROSS & BLACKWELL Elementary/Secondary (0-12) College (1-4 or 5+) 12vrs MACHINE OPERATOR McCORMICK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JAMES HENDERSON ROBINSON MARY WELLS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Cunninghan/DAughter 8640 Winding Way, Perryhall, Md., 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HOLLY HILLS CEM. 10-26-12 MIDDLE RIVER, MARYLAND 21. Signature of Funeral Service Ucensee WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, 321 S PHILA. BLVD., ABERDEEN, MD., 21001 23 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one se on each line Immediate Cause (Final Onset and Death Physician/ cations disease or condition resulting in death) Demen fo Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated assents Due to (or as a consequence of): attending physician and for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ ☐ Live Birth 2 ☐ Fetal dea. ☐ Pregnant at time of death in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No eral Director: A Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical within 24 hou To the Fune completely fi Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) nd title of certi 29d. Date signed (Month, Day, Year) D0071585 10-21-12 Name and address of person who completed cause of death (Item 23a) (Type, Print) \*4105, Balfinare, MO 2120 Shaheeu, 6701 N. Charles 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Veronica Ann Eberlein Month Oct 18, 2012 12:40 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10136 Maple Wood Dr. **Ellicott City** Howard 5. Social Security Numbe If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days 213-82-7095 Director 1 - M 2 X Massac Yrs Jul 9, 1920 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23e or 28e-f show am portant: If item 27 is marked other than "naturel", or items 23e or 28e-f show any injury or other treumatic event, the Medical Evartine must be notified at ence. 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Howard **Ellicott City** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10136 Maple Wood Dr. 21042 U.S.A 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. If Yes, Give Year or Dates White 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ **Edmund J. Slattery** Angelina M. Currie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Burton L. Eberlein Husband 10136 Maple Wood Dr. Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State tery, crematory or other placel **Arlington National Cemetery** Arlington, Virginia 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ RESPIRATORY SECONDARY TO Medical resulting in death) Due to (or as a consequence of): Examiner RAPID VENTRICULAR FIBRILLATION WITH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physicien: The lew requires that the death certificate be executed within 24 hours after death.
To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the Attunetal director, page 2 should be detached for use as the burlai-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 ☐ Other (specify) Pregnant at time of death Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🕅 Residence 6 🗆 Other (Specify) 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 □ Accider 3 □ Suicide 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar

IDV

DHMH 17 Rev 06-2011

29b. Signature and title of pertifier

31. Date filed (Month, Day, Year)

SYED

ul

MD

ABBAS

address of person who completed cause of death (Item 23a) (Type, Print)

6336

32. Registrar's Signature

CEDAR

29c. License number

LANE

D72139

OLUMBIA

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33964 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 18<sup>ay</sup> 2012ª 5:50 P M Mary Christine Emig Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Bel Air Upper Chesapeake Medical Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 155-28-4597 Usual Residence of Decedent **Director** 1 🗆 M 2 💢 F 75 March 29,1937 Pennsylvania or 28a-f shov notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Bel Air Maryland Harford must be r 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 343 Crocker Street USA 21014 item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced þ 1 Yes 2 If Yes, Give Year or Dates. 1 Yes 2 No Specify: Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home h and Mental Hygier 7 is marked other t Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Vincent (unk) DiMassimo Yolanda (unk) D'Arcangelo permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
454 Clyde Bank Drive, Abingdon, Maryland 21009 David Emiq / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 10-20-2012 5 Other (Specify) Bel Air, Maryland Svcs, LLC vice Lip 22. Name and Address of Facility McComas Funeral Home, P.A. Bel Air, Maryland 21014 50 W. Broadway, ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one caus Immediate Cause (Final GLEROVASCULAR ACCOLOGNY Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy 3 Pregnant at time of death Month Day Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has perform 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. completely filled in by the funeral director. Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ot Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1. Natural 5 Pending Division 1 Yes 2 No 2 Accident М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifie 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMULTA SIMITANA, 260 GATEWAY DNIV DRIVB, SUITE 21, 31. Date filed (Month, Day, Year) 2 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar		State of Ma	arylanc		tificat			IIICI IV		Reg. No.	2012	339	365
	Physicia		1. Decedent's Name (First, M.		rie Flyr	າກ						2. Date of Dec	ath	201°9	3. Time of 12:1	
	Medic Examin	al	Lucretia Ros  4a. Facility Name (if not institu			ш		4b. Citv.	Town, or	Location o	f Death	occobc	_	County of Dea		JI M
+	LAMINI		5309 Iroquois					_	hesda					ontgome		
	Funeral Director		5. Social Security Number  564–22–0879  Usual Residence of Decede	_	7. Age	(In yrs. las	st birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da May 8,	y, Year) 192	6 G. Bi	rthplace (State of puntry) Lifornia	r Foreign
	and show dat	ō	10a. State 10b. Co.			10c. City,	Town or Loc	ation							10d. Inside Ci	
	Mary 28a-f	irec		gomer	У	Beth	esda	Lear	0.1							2 X No
	h with the ns 23a or must be i	Funeral Director	10e. Street and Number 5309 Iroquoi:					10f. Zip 208	16				UŠA	zen of What C		
9000	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medicel Examiner must be notified at	ted by Fu	11. Marital Status  1 ☐ Never Married 2 ☐  3 ☑ Widowed 4 ☐ Divo	Married rced	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates.		If	Yes, spe	cify Cubar	Specify:	jin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		14. Race - Am Black, Whi Specify: W		
Maryland 21215-0036	within 72 hou /giene. ner than "nat t, the Medice	Completed by	15. Dec (Specify only I Elementary/Secondary (0-		cation completed) College (1-4 or 5 5+	+)	16a. Deced (Give k life. DO Physic	ind of wo NOT use	rk done d e retired)	uring most	of worki	ing		nd of Business	s/Industry	
d 2	filed wi al Hygie d other vent, <u>tl</u>	Be	17. Father's Name (First, Mide	fle, Last)	<u> </u>		TITYDIC	<u> </u>			er's Name	e (First, Middle,				
ylan	should be file n and Mental P 7 is marked o raumatic eve	۵	Matt Rakela				· · · · · ·			Yerk	a Ba	risic				
	and 2 shoul Health and tem 27 is m		Julie Burke/				6009	Rudy	ard I			hesda,	MD 2	0814		
Baltimore,	permit. Page 1 and 3 Department of Healt Importent: If item 2 eny injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 🛱 Crema 4 ☐ Donation 5 ☐ Ott	tion 3 🗆 Rier (Specify)	emoval from State	Fin	ace of Dispo emetery, cren al Jou	sition (Nai natory or o ITNEY	ne of other place Crei	nator	y 10	Date /23/12	20c. Lo Wood	bine, I	r Town, State	<u> </u>
Balt	permit Depart Import eny inj		21. Signature of Funeral Serv	LH-	elite	MO1	251 Be	verl	y L.	Heck	rott		Cla	P.O 78 rksvil	4 <u>le, MD 2</u>	21029
	Physician/ Medical		shock, or heart failure. Immediate Cause (Final disease or condition	Ba. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												te ween Death
	Examiner				Pulmona:										weeks	
	sit sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	₹ '	Due to (or as a	a conseque	ence of):									
0	cate be executed physician and s the burial-transi	edical Examiner	that initiated events resulting in death) Last	c.	Due to (or as a	a conseque	ence of):							-		
Box 68760	ath certifi attending for use a	₹	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No g ☐ Unknown	23	ic. If yes, outcome  1  Live Birth  4  Pregnant a  9  Unknown	2 Fetal	death 3	Ectopic Other (s		у				23d. Date of d Month	•	Year
s, P.O.	requires that the des been signed by the s should be detached	d by Ph	Part II. Other significant co	nditions con	tributing to death b	ut not resu	ulting in the u	nderlying	cause giv	ren in Part I	l.				to the cause of c	
Records,	ne lew requ te has beer age 2 shou	omplete											psy ormed?	prior to death?	utopsy findings completion of c	available cause of
H E	ien: Ti artificat ctor, p	Be C	25. Was case referred to mer examiner?	_					26. Pla	ace of Dear	th (Chec	1 ☐ Yes k only one)	ZKINO	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	s 2   110	
f Vii	Physic this ce ral dire	욘	1 Yes 2 No 27. Manner of Death	Ho	ospital: 1		ER/Outpatier		Othe 28c. Injury	4 ⊔ Nu		ome 5 🕅 Resi			ecify)	
o uc	nding ath, r: After	icate	1 Natural 5 P	ending vestigation	(Month, Day		injury	М	work	? Yes 2□		zou. Describe	now injury	yoccurred		
Division of Vital	al or Atte s after de il Directo ed in by th	Certificate:		ould not be etermined	28e. Place of Injubuilding, etc		me, farm, str	eet, factor	y, office			28f. Location ( City or To			ural Route Numi	ber,
	To the Hospital or Attending Physicien: The le within 24 hours after death, To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check 2 Med	cal Examine	cian: To the best of er: On the basis of e Practitioner: To th	xamination	and/or inves	tigation, in	my opinio	on, death oc	ccurred a	t the time, date	and place	, and due to the	e cause(s) and ma	anner stated.
	To the within 2 To the comple		29b. Signature and title of ce	rtifier	M	m	on		c. License 05787				29d. Dat Octo	te signed (Mor ber 22	th, Day, Year) , 2012	
7			30. Name and address of pe Roji Menon,	M.D. 1	10901 Con	necti	cut A	ve. #	100	Kensi	ngto	on, MD	20895	5		
	Sta Registr	te ar	31. Date filed (Month, Day, Y	3"2012	32. Registra	ar's Signat	far.	Kal								

				Ear	Pleas amend	#20	/pe or P	rint in Marsia	Black	k Indeli	ble in	k. Ens Tealth	and M	II Copie ental Hy	s Ar	e Leg	ible.	0.0	000
				For amend State Registrar			per fh	g932	10-2	25–12 Certifica	te of L	Death			Reg. N	.20	12	33	1966
		ysiciar Medic		Decedent's Name	e (First, Middle,	- 1			Fo	ord				2. Date of Do	eath	ay 2	Year		of Death
		xamine		4a. Facility Name (if	not institution, q BEAUN			*		4b. Cit		Location			4	c. County	of Death	n	
Cuc		neral ector		5. Social Security N	umber (	6. Sex		Age (In yrs.	last birtho	Month	ler 1 Year			8. Date of Bi (Month, D			9. Birt	hplace (State untry)	
18pm			١	Usual Residence			VI ZAIF	100.0	50 Y	or Location				11-02	-19	61		10d. Inside	
	Marylar	28a-f sl	Director	MD						IMOR	E								es 2 ☐ No
2	/ith the	23a or 3	al D	10e. Street and Nur	nber EAUMO	. (	Aven	ar-		10f. 2	Zip Code	2 24			10g. C	citizen of V		untry?	
7	leath w	items er mu	Funeral	11. Marital Status	епимо		. Was Decede Armed Force	nt Ever in U	I.S.	13. Was Dec		239 ispanic Ori	igin? (Spec	cify Yes or No Rican, etc.)	-	14. Race	e - Amer	ican Indian,	
100 100	within 72 hours after death with the Maryland glene.	ا ا	≨	1 🖾 Never Maπ 3 ☐ Widowed		ed	1 Yes 2 If Yes, Give Year or Date	<b>₩</b> No				Specify.		ilican, cic.,		Specify:	k, White	e, etc. ACK	
0 4	72 hou	n "natu fedical	Completed		15. Decedent ecify only highes		completed)		I (	Decedent's Us	vork done i	during mos	st of workin	ng	16b.	Kind of Bu			- 1
21.0	within /giene.	t, the N		Elementary/Seco	ondary (0-12)		College (1-4	or 5+)		te. DO NOT L OSTAL	1 '		2		u.	s Pos	FAL	SER	vicE
a a	be filed ental Hy	c even	To Be	17. Father's Name (		st)								(First, Middle			<del>)</del>		
Ford	should be file	is marl		19a. Informant's Na		р (Туре,	Print)		19b.	Mailing Addre	ess (Street						State, Zip	Code)	
2	~ 들	item 27 other tra		ANGELA 20a. Method of Disi		1/5	ISTER		56	07 Cy	NTHI	A TEI							206
> 2		- L		1 ⊠Burial 2	Cremation : 5 Cother (Sp		moval from St	ate 200.	King	Park	<b>motor</b> <b>Motor</b>	<del>y</del> _	_	ate //2	1		•	Town, State	
err >	permit. Page Department	Important: I any injury o once.		21. Signature of Fu	1		N M ( ) I	( ( 6		22. Name	and Addre	ss of Facili							SERVICE
12				23a. Part 1. Enter	the disease,	emplica	ations that cau	OO_ used the dea	ath. Do no					BATII respiratory a		E, M	1	Approxin	nate
V V	Physi	_		Immediate Cause disease or condition		ly one o	ause on each	line.	dic'	Rice	155	Ca	rci	MOW	a			Interval E Onset an	d Death
4		edical miner		resulting in death)	1	٢	Due to (or	as a conse	quence of	:									
	p	ısıt	miner	Sequentially list co if any leading to in cause. Enter Unde Cause (Disease or	erlying	b.	Dun to (or	as a nonse	quenne of	-	-					_			
	executed	<u> </u>	I Exami	that initiated event resulting in death)	s	C.	Due to (or	as a conse	quence of	):									
68760	icate be	attending physicis d for use as the bur	Physician/Medica			d.													
8	th certif	trending or use a	ian/N	IF FEMALE: 23b. Was decedent in the past 12	months?	230		th 2 🗆 Fe	tal death	3 🔲 Ectop		Су				23d. Da		,	Vans
S S	the dea	by the a	hysic	1 ☐ Yes 2 ↓ 9 ☐ Unknown	ZNo		4 L Pregna 9 Unknov		f death	5 Other	(specify)					MIO	onth	Day	Year
٥	res that	o d	ক্র	Part II. Other signi	ficant condition	s contr	ibuting to dea	th but not re	esulting in	the underlyin	g cause gi	ven in Part	t I.					the cause of obably 4	
Ž	w requi	hou hou	Completed											24a. Wa	s an	24b. \	Were aut	topsy finding	s available
0	The la														opsy formed? 2 2 1		death?	2 No	cause of
Į.	sician	s certifi directo	To Be	25. Was case referr examiner? 1 \(\sum \) Yes 2	red to medical :: No	Hos	spital:	nationt 2	7 EB/Out	patient 3 🗆	Oth		ath (Check	only one)		с П о <b>н</b> ь	(0	:£.)	
Ş	ling Phy	After this funeral di		27. Manner of Deat	th 5 Pending		28a. Date of		28b. Tir	ne of ury	28c. Injur worl	y at k?	2	28d. Describe					
Division of Vital Becords	Attender death	by the	Certificate:	2 Accident 3 Suicide 4 Homicide	Investiga 6	ot be	28e. Place of	f Injury - At I		M n, street, fact	_	Yes 2	_	28f. Location	(Street a	nd Numbe	er or Rui	ral Route Nu	mber,
Ë	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Linear Information this conflictor has been singed by the attending physician.	neral Di y filled ir		29a. Certifier	Certifying	Physici	an: To the bes	t of my kno	wledge, de	eath occurred	at the tim	e. date and	d place, an	City or To	cause(s)	and mann	ner as st	ated.	
	the Ho	the Fur	Medical	(Check 2 only one) 3	Medical Ex	aminer	: On the basis	of examinat	ion and/or	investigation, edge, death o	in my opini occurred at	on, death o the time, da	occurred at	the time, date	and place the caus	e, and due se(s) and n	e to the o	cause(s) and s stated.	manner stated.
	გ ≩ გ	<b>2</b> 8		29b. Signature and	ville of certifier	ade	ettu	2>			9c. Licens	SSU	16		29d. D	ate signed	8 (Month	i, Day, Year)	
10				30. Name and addi	ress of person of	no com	pleted cause	5601	Lo	ch P	zver	1 Ru	wQ.	Ralt	imo	ra,	hip	2(23)	)
	R	Stat legistra		31. Date filed (Mon	th, Day, Year) CT 2 3 2	012	2. Reg	jistrar's Sigr	ure 4	barker	,								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Elizabeth Livingstone Field 10:05 P M 2012 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Symphony Manor - Assisted Living Baltimore Funeral Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Min. Months Hours (Month, Day, Year) 05/04/1930 Michigan Director 1 DM 2 F) F 370-30-2370 Yrs should be filed within 72 nours and Mental Hygiene.

I is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show arise event, the Medical Examiner must be notified at 10a, State 10b Count 10c. City, Town or Location 10d. Inside City Limits Director X□ Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4301 Roland Avenue 21210 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Š Maryland 21215-0036 1 ☐ Yes 🎾 No 3 Widowed 4 Divorced Specify Completed ear or Dates. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Department of Health and Mert Department of Health and Mert Important: If item 27 is marked any injury or other Palmer Livingstone Helen Wilkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peder Michael Field / Son 2906 Shirey Avenue, Baltimore, MD 21214 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 10/20/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota <u>Marshall</u> Maryland Cremation Services, PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Pnysician/ ebulu disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exam Cause (Disease or Trijury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year ☐ Pregnant at time of death☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) ASSISTED LIVING Hospital 1 ☐ Yes 2 No Other: ည 4 Nursing Home 5 Residence 6 M Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signa and title of certifie 29c. License number

DHMH 17 Rev 06-2011

State Registrar

NOVAM

31. Date filed (Month, Day,

(0701

and address of person who completed cause of death (Item 23a) (Type, Print) WES

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month James Fisher 4:13 A M Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c County of Death Mari Com ER 5. Social Security Number AVENT MKomA If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 578-52-9347 Months Days Hours (Month, Day, Year) Country) Director 70 1X M 2 □ F 06-11-1942 Wash. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Md PG College Park 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9314 Cherry Hill Rd #927 20740 U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 XNever Married 2 Married à Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Disabled None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Fisher Sr Pearl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20740James Fisher III (son) Cherry Hill College Pk Rd #927 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 10-18-12 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Terry A. NW. Wash Austin Funeral Sev DC 20011 3821 14th St 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ Pheroiderni Cando disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of). Hospital or Attending Physicien: The law requires thet the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): after death.

I Director After this certificate has been signed by the attending physician in by the funeral director, page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, ၉ 1 🗌 Yes ER/Outpatient 3 DOA 1 🗌 Inpatient 2 🔄 Certificate: 28a. Date of injury (Month, Day, Year) 27. Mannes of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director Af completely filled in by the fu work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number rson who completed cause of death (Item 23a) (Type, Print) 1600 Mecina 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ October 21, 2012 Allen Gaslow 1630 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. . Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Jan 20, Year 932 New York Director 088-24-4417 80 1 X M 2 □ F Usual Residence of Decedent 28a-f shov r than "natural", or items 23a or 28a-f sho the Medical Examinar is ust be netflied at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo MD 1 Yes 2 XNo Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3122 Gracefield Rd. Unit 613 20904 USA 12. Was Decedent Ever in U.S. Amped Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates. 1954-56 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Sales Manager Office Furniture Be 17. Father's Name (First, Middle, Last) should be file and Mental H 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental F itam 27 Is marked o Abraham Gaslow Molly (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14115 Artic Avenue Rockville, MD 20853 Susan St. Aubin/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place)
Final Journey Crematory 10/24/12 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Name and Address of Facility tion Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ a Metastatic Carcinoma of the Bladder vear Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) the the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Xunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an s certificate has t director, page 2 s autopsy 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No Certificate: To 1 Ninpatient 2 ER/Outpatient 3 DOA within 24 hours after death,

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5  $\square$  Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number

Registrar DHMH 17 Rev 06-2011

State

Mark A. Parkhurst, M.D. 3110 Gracefield Rd. Silver Spring, MD 20904

egistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

OCT

D24093

29d. Date signed (Month, Day, Year)

October 22, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Mother Physician/ Medical Examiner 4c. County of Death mure n/a Date of Birth **Funeral** 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign (Month, Day, Year) Months **Director** 1 🕅 M 2 🗆 F 62 July 31, 1950 Pennsylvania er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🛶 No Pennsylvania York York 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 900 Ridgewood Road 17406 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 **X** No If Yes, Give Year or Dates 1 Yes 2 No Specify 3 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the A once. Grinder Caterpillar Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Larry Goodling Dorcas Ehrhart ge 1 and 2 should b 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lauren Goodling/wife 900 Ridgewood Road York, Pennsylvania 17406 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 10/22/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facilit Cremation Society of Maryland, Inc. re of Funeral Service License Stephanic Custer 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of pying, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to lot as a consequence of use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death page 2 should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 Yes 2 No 1 🗆 Yes after death.

Director: After this certifice d in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 No Other: ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Edward Goodrich 2012 7:15 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death The Sanctuary at Holy Cross Burtonsville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Director 577-01-2101 1 🗓 M 2 🗆 F March 23,1913 Washington DC rai", or items 23e or 28e-f show Exeminer must be notified at 10a. State 10b. Count filed within 72 hours efter death with the Maryland 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits MD Montgomery Silver Spring 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14905 Claude Lane 20905 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces ģ Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) C&P Telephone Co. Elementary/Secondary (0-12) College (1-4 or 5+) 2 Utilities Electrical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 end 2 should be file if Health and Mental F item 27 is marked o ဂ္ Charles Edward Goodrich Caroline Κ. Greenlee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Edward E. Goodrich, Jr./ Son 14905 Claude Lane, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Depertment of Himportant: If ite any Injury or ot once. 20c. Location - City or Town, State Pege 1 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 10/23/2012 Beltsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD M00382 20910 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition ADVANCED DEMENTIA Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exam the Hospitei or Attending Physician: The law requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? after death. Director: After this certificate 1 Yes 2 No To the Hospitei or Attending Physician: within 24 hours after death.

To the Funerei Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) \_2 ☑ No 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29c. License number D0054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #1-17: SILVER SPRING MD 20902 BHOGAVILL MD. 9801 GEORGIA

DHMH 17 Rev 06-2011

State Registrar 32. Registra

12-07854 Carol A Galindo Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

aror A Gailligo		1-For State Continually and Department of Health and Mental Page 14 Certificate of Death Registrar		201	2 3397		
Physici		Decedent's Name (First, Middle,Last)	2. Date of Deat		3. Time of Death		
Medical Exami	iner	odfof h. odffido	Month October 1		1640 hrs		
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Dea  Baltimore Washington Medical Center  Glen Burnie	ın	4c. County of Death Anne Arundel			
Funeral Director		5. Social Security Number $215-92-7778$ 6. Sex $1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 $		th(MM/DD/YYYY) 9. Bird Foreig / 1963 Co	hplace (State or n <sup>untry)</sup> Maryland		
*ny		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
Maryland 28a-f show 1 at once.	ō	Maryland Anne Arundel Gambrills			1 Yes 2 X No		
r death with the Maryland or items 23a or 28a-f sho must be notified at once	Dire	10e. Street and Number 2416 Sunshine Way 21054	10	Og. Citizen of What Cour United	T.		
b, MD 21215-0036  and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene.  tem 27 is marked other than "natural", or items 23a or 28a-f she trammatic event, the Medical Examiner must be notified at once	/ Funeral	11. Marital Status  1 Never Married 2 Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 12. Was Decedent Ever in U.S.  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 No  1 Yes, Sive Year 1 Yes 2 No specify:		14. Race - Ameri White, etc.	can Indian, Black,		
ours af	bd by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind or during most of working life. DO NOT use re		16b. Kind of Business/I			
nore, MD 21215-0036 ages I and 2 should be filed within 72 h nt of Health and Mental Hygiene. It: If tiem 27 is marked other than "no other traumatic event, the Medical E.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  12 Office Work	eurea)	Car Deale	chin		
d with	E O		ne (First, Middle, N	<u> </u>	ЗПЕР		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Stephen Tyma Margare					
MD 2.  rd 2 should the and M. m 27 is m. aumatic c	မ	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of 2416 Sunshine Way, 0					
e, M l and 2 Health item 2		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or			
Pages lent of lunt: If		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Metro Crematory Inc. 10/	18/2012	Baltimore.	Marvland		
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Mes		21. Signature of Funeral Service Licensee Alyson & Taylor 22. Name and Address of Facility Cr. 299 Frederick Road	emation	Society of	Maryland		
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.			Approximate Interval		
/Medical Examiner		Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiov	ascular	<u>Dis</u> ease	Between Onset and Death		
	1	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.		-	24.0		
	miner						
4	Exami	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):					
OX 68760, sath certificate be executed attending physician and for use as the burial - transit	E E	d.					
50, te be ex ysician burial	Medical	■ UNPENDED AMENDED 23a,27,per me,g934 12-12-12 st	n 				
5876 ertificat ling ph	an/N	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregr	ancy	23d. Date of delivery Month D	ay <b>Y</b> ear		
JOX (leath ce attended for use	Physician/I	4 ☐ Pregnant at time of death 5 ☐ Other (Specify) 9 ☐ Unknown		f	1		
b.O. Bothat the dedetached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	bacco use contribute to t	he cause of death?		
S, P.C uires that signed!	ed by		1 Yes	2 No 3 Prob	ably 4 🗹 Unknown		
Cords law requas been been been been been been been bee	plet		24a. Was a autops	prior to co	opsy findings available ompletion of cause of		
tal Rec	Completed		perform 1 ✓ Yes 2	med? death? ! No 1 ✓ Ye	s 2 No		
/ital sician: is certi lirector	Be	25. Was case referred to medical examiner?  1 Ves 2 No  1 Inpatient 2 ER/Outpatient 3 DOA  Other Nursi	ng Home 5	Residence 6 Other:			
n of \ ing Phy After th	1	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		ow injury occurred			
sion ttendi death. ctor: /	atio	1 X Natural 5 pending 2 Accident Investigation					
Division of Vital Records, P.O. Box 68760, In the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	Certification:	3 Suicide 6 Could not be determined (Specify) Suicide (Specify)	28f. Location (S or Town, St	treet and Number or Rur ate)	al Route Number, City		
Hospit 24 hour Funer tely fill		4 Homicide (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an	d due to the cause	e(s) and manner as state	d.		
To the Howithin 24 h To the Fu	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date a	and place, and due to the	cause(s)		
	Σ	29b. Signature and title of certifier  29c. License number		29d. Date signed (Mon			
Word		30. Name and address of person who completed cause of death (Item 23a)		October 18, 2012			
~		Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Balt	imore, MD 21	223			
St Regist		31. Date filed (Month, Day, Year) 32. Residants Signature					
DHMH 17 Rev 1/2		ORIGINAL		OCME			
		SAMICHAL)		111.70%			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edward Month Gatling 2139 M 2017 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brompton Battimore Dcheam If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days (Month, Day, Yearl **Director** 21 show or 28a-f shov notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD Locheam 1 ☐ Yes 2 🎞 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a Brompton 21207 US4 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or itel þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. Specify: Black 1 ☐ Yes 2 No Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than matic event, the Me College (1-4 or 5+)
5+ Kars Elementary/Secondary (0-12) (5atl Professor Education 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental I William Gatling Naomi ames 19a. Informant's Name/Relationship (Type, Pfint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trau 4216 Wynfield Drive Owings Mills MD 21117 Gattin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 10/27/2012 4 ☐ Donation 5 ☐ Other (Specify) Windsor Mill, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral Services Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ a.Arterio ardiovascular disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical that the death certificate be P.O. Box 68760 se asn. 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, pertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 1 Yes 2 No 1 Yes funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 □ No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 1 Natural 28d. Describe how injury occurred 5  $\square$  Pending injury s after death. Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number completed cause of death (Item 23a) (Type, Print) eHillCT. Lythe Trimb OCT 2 3 2012 State Registrar

N

~

0

2/61/0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charles L. Greason Sr. october fg, 20 12 9:14а м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore Towson Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours 213-32-7211 July6, 1934 Director 1 DM 2 DF 78 MD Usual Residence of Decedent ir then "neturel", or Items 23e or 28e-f show the Medical Evantiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Essex 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 207 Mace Avenue 21221 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72, and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Union Rep. Teamsters 311 2vrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be George Greason Myrtle Dieter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 end 2 sh Department of Heelth an Important: if item 27 is any injury or other trau Gloria Greason /wife 207 Mace Avenue Baltimore MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 1 Cremation 3 Removal from State 4 Donahion 5 Other (Specify) Bayview Crematory or other place) 10/22/12 Baltimore MD 21. Sign 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Athenoscland Physician/ disease or condition resulting in death) Medical Due to (or as a consequence or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examin To the Hospitel or Attending Physician: The lew requires thet the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate hes been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be deteched for use as the burlel-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Day 9 Unknown stributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of 119 24a. Was an 390 autopsy 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature d title of certifie son who completed cause of death (Item 23a) (Type, Prin 0 State Registrar

		For State	State of Ma	-	•			lental Hy	giene			
		Registrar  1. Decedent's Name (First, Middle, Last	)		Certificate	or Death	1	Reg. No.  2. Date of Death  3. Type of Death				
Physicia Medic Examin	al	80 4a. Facility Name (if not institution, give s	eatrice K.	Glazer	4b City To	own, or Location	on of Dooth	October 18, 2012 9:00				
Examin.	er	Brighton		4b. City, 10	Bethe			40.00		ntgomery		
Funeral Director		5. Social Security Number 6. Sec		(In yrs. last birth			der 24 Hrs.	8. Date of Birt (Month, Day	h 7 1916	a Rint	hplace (State or Foreign untry) New York	
nd now	_	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					-	10d. Inside City Limits	
arylar ka-fsh ified a	ecto	Maryland Montgo	1	Too. Oity, Town		North E	Rothox	da			1 Yes 2 X No	
the M or 28	Ē	10e. Street and Number	merg		10f. Zip C		<u>ieines</u>	uu	10g. Citize			
h with	Funeral Director	5550 Tuckerma	ın Lane, #.	458		208	352			и.	S.A.	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X N If Yes, Give		13. Was Deceder If Yes, specify	/ Cuban, Mexi	can, Puerto	cify Yes or No- Rican, etc.)		. Race - Amer Black, White ec <i>ify:</i>		
hours natura ical E	ete	15. Decedent's Ed		16a, [	Decedent's Usual (	Occupation				of Business I		
in 72   e. nan "r	Completed	(Specify only highest grad	de completed) College (1-4 or 5+	.) (	Give kind of work of ife. DO NOT use re	done dunng m etired)		Ĭ				
d with lygien ther th	oo l		4	R	eports Co				<del></del>		of Defense	
be file ental F ked of	면	17. Father's Name (First, Middle, Last) Solo	other's Name			,						
hould ind Me s mar umati	1	19a. Informant's Name/Relationship (Typ	Mailing Address (5	Street and Nun	nber or Rura		Je, Maiden Sumame)  Sie Kramer  Joher, City or Town, State, Zip Code)  Moni, Iowa 50140  20c. Location - City or Town, State  C. Olney, Maryland  Maldi Funeral Home, Inc.					
nd 2 sl ealth a n 27 i		Steven Glazer - S	Son	3:	20 South	Cedar	Stree	t, Lamo	ni, I	owa 50	140	
ge 1 ar t of He if iter or oth		20a. Method of Disposition 1	Removal from State	20b. Place of semetery	Disposition (Name crematory or other	of er place)	[	Date	20c. Loca	tion - City or	Town, State	
it. Pag intmen intant: njury		4 Donation 5 Other (Specify)	)	Judean								
Depar Impo any ir once		21. Signature of Funeral Service License  Ann May	Warner	1232	22. Name and A	M Hamp	cility Hin shire	es-Rina Ave.,S	ldi F ilver	uneral Spring	Home, Inc. 3,MD 20904	
		23a. Part 1. Enter the disease, or complete shock, or heart failure. List only on	lications that caused t e cause on each line.	the death. Do no	t enter the mode o	of dying, such	as cardiac o	r respiratory arr	est,		Approximate Interval Between	
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)		ensive (	<u>Cardiova</u>	scular	Disea	se			Onset and Death	
Examiner	Н		Due to (or as a	consequence of	).							
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of	):				·			
executed an and ial-transit	xam	Cause (Disease or iinjury that initiated events resulting in death) Last	Due to for as a	consequence of	<u> </u>	_						
be exe sician burial		resulting in death) Last	. Due to (or as a	consequence or	)•							
ficate graphys by the	<b>l</b> edical		d									
ending r use a		23b. Was decedent pregnant	3c. If yes, outcome of 1 Live Birth 2		3 🗆 Ectopic pre	anancy			230	d. Date of deli	ivery	
the att	ysici	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4 ☐ Pregnant at t g ☐ Unknown		5 Other (spec					Month	Day Year	
hat the ed by detach		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contrib								contribute to	the cause of death?	
n sign	ed by							1 🗆 1	/es 2 💢 I	No 3□Pr	obably 4 🗆 Unknown	
w requires been standing should be s	plet							24a. Was a			opsy findings available	
The la ate ha page a	Completed							autop perfor	med?	death?	completion of cause of	
cian: sertific ector,	Be	25. Was case referred to medical examiner?	lospital:			26. Place of D	eath (Check		7			
Physic ruthis cural dir	욛	1 ☐ Yes 2 💢 No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐			ne of 28c	Other: 4  Injury at		me 5 Resid			Assisted <del>Maring -</del>	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Certificate:	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day,		ury M	work?		eod. Describe in	ow injury oc	currea		
or Atte	Serti	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.		n, street, factory, o	ffice		28f. Location (S City or Tow		umber or Run	al Route Number,	
spital ours a leral D	ledical (	29a. Certifier 1 Certifying Physic	cian: To the best of m	v knowledge de	eath occured at the	e time date ar	nd place and	due to the car	see(e) and m	annor on eta	tod	
he Hos in 24 h he Fur pleted	Medi	(Check 2 Medical Examinonly one) 3 Certifying Nurse	er: On the basis of exa	amination and/or i	investigation, in my	opinion, death	occurred at	the time, date as	nd place, and	d due to the c	ause(s) and manner stated.	
Vith to the com		29b. Signature and title of certifier			29c. L	icense numbe		1		igned (Month		
12/1		hand				D00	064024		Oct	ober 1	9, 2012	
1,01		30. Name and address of person who co	mpleted cause of dea	ath (Item 23a) (Ty 1125 Ro	pe, Print) Ckvillo	Pike. #	<sup>‡</sup> 110.	Rockvil	le. M	arulan	nd 20852	
State Registra	e	Janha Lachtchining 31. Date filed (Month, Day, Year) OCT 23 2012	2. Registrar	s Signature	acked				7			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 19a Per FH G932 10/31/2012 JH State of Maryland / Department of Health and Mental Hygiene For

			State Registrar					Certifica	te of L	Death		Re	eg. No. 🗸	2010	2. 22076	
	Physicia	an/	Decedent's Name (First, Michael Control of the			0: 1						2. Date of Death Month		Year	3. Time of Death	
	Medi	cal	An English Name of an institu		seph M.		ner					October				
	Examir	ner	4a. Facility Name (if not institu			oer)		4b. Cit		r Location			4c. County of Death			
	Funeral		5. Social Security Number	6. Sex	(	7. Age (In yı	rs. last birth	day) If Unc	er 1 Year		chase	8. Date of Birth		_	tgomery hplace (State or Foreign	
	Director		579-05-1417 Usual Residence of Decedent	1 🕅	(M2□F		94	rs. Month	Days	Hours	Min.	(Month Pay, 12/15)	1917	Was	hington, DC	
	and show	ē	10a. State 10b. Cou	nty		10c.	City, Town	or Location							10d. Inside City Limits	
	e Maryl r 28a-f notifie	Director	Maryland Mo	ntgo	mery			1106 7	Cl ip Code	hevy	Chase				1 X Yes 2 No	
	th with th ms 23a o must be	Funeral	3315 Shi						•		815	3			S.A.	
9800	perriit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show minury or other traumatic event, the Medical Examiner must be notified at once.	<u>چ</u>	11. Marital Status 1 ☐ Never Married 2 <b>X</b> № 3 ☐ Widowed 4 ☐ Divon	/larried	12. Was Deced Armed For 1 XYes If Yes, Give Year or Dat	ces? 2  No <b>1</b>		ŀ		IIspanic Oi an, Mexica Specify		ify Yes or No- ican, etc.)		Race - Amer Black, White ecify:		
21215-0036	ould be filed within 72 hours aftind Mental Hygiene. marked other than "natural", matic event, the Medical Exar	Completed	15. Dece (Specify only hi Elementary/Seconday (0-1:			4 or 5+)		Decedent's Us (Give kind of w life. DO NOT u	ork done ( se retired)	during mo:	,	g		of Business I red. S.	ndustry Gichner	
	d with lygien ther th	Be C			4			Vic	. Pre	side	nt			Iron	Works	
Maryland	d be filed Jental H arked of tic ever	lo B	17. Father's Name (First, Middle		S. Gio	hner				18. Moti	ner's Name	(First, Middle, M <b>Tino</b>	aiden Sur. L <b>Fis</b>			
Man	2 shoulk th and N 27 is ma trauma		19a. Informant's Mame/Relation Sonya S. Gic			10		_				Route Number, 0	-		,	
	e 1 and 2 s of Health If item 27 or other tra		20a. Method of Disposition  1 X Burial 2 Cremati		· · · · ·	201	b. Place of	Disposition (Na	me of					tion - City or		
Baltimore,	permit. Page 1 Department of Important: If is any injury or c		4 Donation 5 Other	r (Specify)	e	Ki		ivid Me	m Gra	dns					ch, Virginia Home, Inc.	
Ba	permit Depar Impor any in	L	Accusação	mllh	nn	123		11800	New	Hamp.	shire	Ave., Si	lver		g,MD 20904	
	Physician/ Medical		23a. Part 1. Enter the disease shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	or complist only one	e cause on eac	h line.	em	104	-	ng, such as	s cardiac or	respiratory arres	it,		Approximate Interval Between Onset and Death Years	
-	Examiner	er	Sequentially list conditions,	l t	o. —											
	uted Id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	₹.	Due to (or as a consequence of):											
_	sate be executed physician and the burial-transit		resulting in death) Last	L	Due to (c	or as a cons	equence o	f):								
38760	ficate g physis the	Medical			J											
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.  within £4 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2		Birth 2 Fant at time	etal death	3		су			230	I. Date of deli Month	very Day Year	
s, P.O.	ires that t signed b d be deta	d by P	Part II. Other significant cond	litions cor	ntributing to de	ath but not	resulting in	the underlying	cause giv	ven in Part	il.	23e. Did tobacco use contribute to the cause of de 1 ☐ Yes 2 🏋 No 3 ☐ Probably 4 ☐ U				
cord	law requ has been e 2 shoul	Completed by										24a. Was an autopsy	2	4b. Were auto	opsy findings available ompletion of cause of	
R	icate icate r, pag		25. Was case referred to media									perform 1 Yes 2		death?	2 🗌 No	
ita	siciar certif irecto	Be	examiner?  1 Yes 2 XNo	_	ospital:				Othe		ath <i>(Ch</i> eck c					
of V	ing Physical distribution	ate: To	27. Manner of Death  1 X Natural 5 Per	ndina	28a. Date o		28h. Ti	patient 3 🗌 [ me of jury	28c. Injury work	4 ⊔ N y at k?	28	e 5 X Resider 3d. Describe how			(y)	
Division of Vital Records,	l or Attend after death Director: # I in by the f	Certificate:	2 Accident Inve	stigation uld not be ermined	28e. Place of building	of Injury - At g, etc. (Spe	home, fari	m, street, facto		Yes 2	_	3f. Location (Stre City or Town,		umber or Rura	al Route Number,	
	Hospita 24 hours Funeral sted filled	Medical	(Check 2 L Medica	al Examine	er: On the basis	s of examina	tion and/or	investigation, in	my opinio	on, death o	ccurred at th	due to the cause ne time, date and	place and	due to the ca	ause(s) and manner stated	
	To the Comple	Ž	only one) 3 L Certify 29b. Signature and title of certi	ing Nurse	Practioner: T	the best of	my knowle	dge, death occ	urred at the	e time, dat e number	e and place,	and due to the c	ause(s) an	d manner as s gned (Month,	stated.	
	M/X)		30 Name and address of	Y C	moleted	0/0	om 22-1 7	(Do Print)	D:	394	154		10	1/8	12012	
	12 0		30. Name and address of personal Lisa McConnel	e. M	.D. 55	530 Wi	scon	sin Ave	nue,	#144	5, Ch	evy Cha	se, 1	laryla	nd 20815	
	Stat Registra		31. Date filed <i>(Month, Day, Yea,</i> QCT 23	2012	32. Re	gistrar's Sig	nature	aked								

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Traver 0:50HM ar 20/2 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death lezabeth Wrsing center <u>Baltimore</u> 5. Social Security Number 8. Date of Birth (Month, Day, Year) Apr 25, 1921 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Months Davs Hours 176-16-1543 Pennsylvania Director Usual Residence of Decedent 28a-f show 10a. State 10b. County other traumatic event, the Mediral Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Baltimore MD ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21201 USA 124 W. Franklin Street and Mental Hygiene. Is marked other than "natural", or items within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. \$ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: white Specify Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) food industry 0 waitress Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Michael Wadsworth Mary Callham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Michael Miller/son 11 S. Calhoun Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ò 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 10-22-2012 Glen Burnie, MD 5 Nother (Specify) in state any injury 22. Name and Address of Facility Simplicity Crem & Fun Services State Anatomy Board Cookinge RD Hanover, MD 21201 7090 Ridge RD Hanover, MD Signa Ronald rector Board 7090kidge ku Hanover, Mo Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ oronar disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner physician and s the burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events YHENT Due to (or as a consequence of): resulting in death) Last Box 68760 attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 5 Other (specify) ed by the a 9 Unknown Unknown P.O. Part **U. Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? Be Completed by To the Hospital or Attending Physician: The law requires a within 24 hours after death.
To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 X No 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: Medical Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 0 Name and address of person who completed cause of death (Item 23a) (Type, Print) tvenue. 31. Date filed (Wonth Day, OCT 2 3 0 Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20<sup>r</sup>12 Patricia Gail Goddard 7:15 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4006 Metzerott Road College Park Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Pay 19940 **Funeral** Age (In yrs. last birthday 9. Birthplace (State or Foreign 1 🗆 M 2 🖰 F Days 217-36-8138 County land 72 **Director** 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 🔀 Yes 2 🗆 No MD Prince George's College Park 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 4006 Metzerott Road 20740 **USA** death ' "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 X Married 2 Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify. Completed 3 Widowed 4 Divorced White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Ith and Mental Hygie 27 is marked other r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles F. Daniels, Sr. Leona Seaton 19a. Informant's Name/Relationship (Type, Print) ent of Health a Richard Charles Goddard / Husband 4006 Metzerott Road, College Park, MD 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department o Important: If any injury or Chesapeake Crematory 10/24/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Souls Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Day to for each domisionary of cause. Enter Underlying Exami Cause (Disease or injury that initiated events Due to (or as a consequence of) the burialresulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy jo Month Dav Year ed by the at detached for Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Tes peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗌 Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 🗌 No Accident Investigation filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and manner stated Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the

bV

State Registrar

095 Marshaloe Drive 31 Date filed (Month, Day, Year) 23

of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death October 18, 2012 Physician/ 9:06 A M Kwang Han Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Adelphi 10321 Floral Drive If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days Hours (Month, Day, Year) 141-86-0515 Director 1 ☑ M 2 ☐ F Nov. 7, 1939 China 10d. Inside City Limits i Hygiene. othar then "neturel", or itame 23e or 28e-f eho vent, the Medical Examiner must be mottlind at 10c. City, Town or Location 10a. State within 72 hours efter death with the Merylend Director 1 Yes 2 No Adelphi MD Prince George's 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Funeral China 20783 10321 Floral Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. <u>۾</u> 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Asian If Yes. Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Research Engineer Geology B 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t of Health end Mentel | If Item 27 is merked o Wenmin Yang should be Tingdong Han 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pege 1 and 2 sh Department of Health er Important: If Item 27 is eny Injury or other trau 10713 Cloverbrooke Dr. Potomac, MD 20854 Rayching Han / daughter 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Final Journey Crematory 10/22/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee Coing Home Cremation Service P.O. Box 784 M01651 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician Renal Cancer ase or condition resulting in death) Medical Due to (or as a consequence of): Examiner Cancer Metastatic to Lung Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) • Hospitel or Attending Physicien: The lew requiree that the deeth certificate be executed 24 hours after deeth.
• Funeral Director: After this certificate has been signed by the attending physicien and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FFMALE yes, outcome of pregnancy

Live Birth 2 Petal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) 1 Yes 2 5 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 XNo 3 Probably 4 Unknown Division of Vital Records, Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy
performed?

1 Yes 2 No 1 Yes 2 No 8 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\boxtimes$  Residence 6  $\square$  Other (Specify) 1 Yes 2 🗐 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No 1 X Natural 5 Pending 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hospi within 24 hou To the Funer completely fil 29a. Certifier 2 Sertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Sertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature d title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 19, 2012 D0044883 30. Name and address of person who compered cause of death (Item 23a) (Type, Print) Thuan-Hoa Nguyen 12201 Plum Orchard Drive Silver Spring, MD 20904

State

Registrar

31. Date filed (Month, Day, Year)

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Oct. 2012 Pandu Handulnagaram 21 7:50 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11828 Steeplebush Drive Clarksburg Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Director 1 🛛 M 2 🗆 F Yrs 68 Oct. 18,1944 India ral", or items 23a or 28a-f shov Examiner must be notified at. 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Andhra 1 Ty Yes 2 No pradesh W. Marredpally Secunderabad 10f. Zip Code 10g. Citizen of What Country? Funeral Flat #19, Sneha Enclave 500026 India 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 🖾 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: 3 Divorced 4 Divorced Specify: Asian Indian Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Mechanical Engineer Indian Railways Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Venkiah Handulnagaram Mallamma Handulnagaram 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 is or other tra Sudheer Handulnagaram 11828 Steeplebush Dr. Clarksburg, MD 20871 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any Injury or ot 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) inal Journey Crematory 10/22/12 Woodbine, MD Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 M01651 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Alcoholic Cirrhosis disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🔀 No 1 Tes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 X Other (Specify) Home 1 🗌 Yes 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No neral Director: A / filled in by the fi 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Signature and title of certifier 29c. License number D0063195 MD October 21, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Wilks, M.D. 1335 Piccard Dr. Suite 100 Rockville, MD 20850 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

State

3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 October 11:10A M Barbara Fav Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Prince Georges Southern Maryland Hospital Clinton Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days Hours (Month, Day, Year) Director 570-76-4161 1 🗆 M 2 🔀 F 01/12/1956 56 Washington, DC Usual Residence of Deceden ir then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b Count 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 No Prince Georges Brandywine 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20613 U.S.A. 12201 Brandywine Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Completed Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 all Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) Government Information Technology Specialist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental F 27 is marked of traumatic ever DeShazo Pearlina Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau once. 7506 Clinton Vista Lane, Clinton, MD 20735 Adrienne D. Harrell / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 10/19/2012 4 🛛 Donation 5 🗌 Other (Specify) Anatomy Gifts Registry Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry Signature of Funera Service Licen 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Mera Dronn Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No Month Day 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown cate has been sig r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' eral Director: After this certificate I filled in by the funeral director, pag Yes 2 X No 1 ☐ Yes 2 ☐ No B B 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Yes 2 🕅 No 욘 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation
6 Could not be ☐ Accident ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completely filled Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature, and title of certifier 29d. Date signed (Month. Day, Year) D0064289 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

<u>Varsha Vanika M</u>D

31. Date filed (Month, Day, Year)

7503 Surrats Road,

32. R gistrar's Signature

Clinton, MD 20735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 19a-b, per fn, g933 11-2-12 sm
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Wendell P. Hartley 2012 October Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Glen Meadows Glen Arm 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Month, Day, Year) 21, Days Min 281-05-0103 Director 1**X**XM 2 ☐ F 100 Yrs. Ohio 1912 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health end Mental Hygiene. Importent: If item 27 is merked other then "neturel", or items 23e or 28e-f sho eny injury or other treumetic event, the Medical Evanthing must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Hunt Valley 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? United States Funeral 21030 203 Wickersham Way of America 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2XXNo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: white Specify: 3 N Widowed 4 Divorced Hantley Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Insurance Agent Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Celia J. Vining William B. Hartley 19a. Informant's Name/Relationship (Type, Brint) Nancy J. Lilliston/Daughter Tronster Hartley/ grandson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Way, Hunt Valley, Maryland 21030 2970Wickersham 20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Funeral Chapel - Bel Air 20a. Method of Disposition 20c. Location - City or Town, State October 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 2012 20. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, PA
2325 York Road Timenium, Maryland 21093 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician CFLL A disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami physicien end s the burlef-trans! Cause (Disease or injury that initiated events resulting in death) Last certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 use es t ettending | IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ The law requires that the deeth in the past 12 months? Day Year Yes 2 □ No ate has been signed by the e page 2 should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MENTIA -ZHEIMER Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 12 No hin 24 hours after death.

the Funerel Director: After this certificate I
mpletely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide Hospital or Attending 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours To the Funerel Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature nd title of certific 29c. License number 29d. Date signed (Month, Day, Year) 10/19/12 amana W erson who completed cause of death (Item 23a) (Irine, Print) RUSSROADS #159 BALTIMORE RAM ANA 401 31. Date filed (Month, Day, Year) State Registrar

e10e/81/01

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death nt's Name (First, Middle, Last) Physician/ 2012 20PM ouise Medical not institution, give street and number) County of Death Examiner 4b. City Town, or Location of Death lowson more tospice If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Min. Hours Director 1 M 2 F 16 in than "natural", or items 23a or 28a-f show the Medical Evaminer must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 59 Funeral 21 death \ 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 14. Race - American Indian and Mentel Hygiene. is marked other than "natural", or δ 1 Never Married 2 Married Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 ☐ No Specify: 3 ₩Widowed 4 □ Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO VQT use retired) (Specify only highest grade completed) College (1-4 or 5+) esk Be other traumetic event, ather's Name (First, Mother's Name (First, Middle, Mai ည and 2 should be les (Daughter 19b. Mailing Address (Street an permit. Pege 1 and 2 sh Department of Heaith ar Important: If Item 27 is any injury or other trau Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 25 4 ☐ Donation 5 ☐ Other (Specify) nunsville. Six alure of Funeral Service Licens 23a. Part 1. Entertile disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner mentia ENS Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Privi fu (ur as a nonsequence of) Exami attending physician end I for use as the buriei-trensit The lew requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atter in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records, Completed 1 Yes 2 No 3 Probably 4 ☐ Unknown s certificete has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes or Attending Physician: within 24 hours after deeth.

To the Funerei Director: After this certific completely filled in by the funeral director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No hospice မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1)X) Natural 2 Accident 5 Pending injury Division 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check the th only one 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day) 32. Registrar's Signatur

DHMH 17 Rev 06-2011

State Registrar

			Please Type or amend State	Print in Black	k Indelible Inl	k. Ensure Al	Copies A	re Legible	
		•	For State State Registrar		Certificate of L		Reg.	0010	33986
	Physicia Medic		1. Decedent's Name (First, Middle, Last)	tund by		Ó	2. Date of Death	18, 2012	3. Time of Death 6:20 P M
	Examir		4a. Facility Name (if not institution, give street and nu	ospice	4b. City, Town, or	Location of Death		4c. County of Dea	th
	Funeral Director		5. Social Security Number 6. Sex () 1 M 2 W/F	7. Age (In yrs. last birtho	Months Days		8. Date of Birth (Month, Day, Yea	r) Co	thplace (State or Foreign untry)
	show	or	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town o	or Location		JIJATI	930	10d. Inside City Limits
	e Maryli r 28a-f	Director	10e. Street and Number	Bal-	10f. Zip Code		100	Citizen of What Co	1 Yes 2 No
	within 72 hours after death with the Maryland giene. er then "naturel", or items 23e or 28a-f sho , the Medical Examirer must be mytfiled at	Funeral	1100 Bolton House	Apt. 405	5 21	201		US.	A
စ္က	fer deat , or iten	þ	1 Never Married 2 Married Armed F	edent Ever in U.S. orces? 2 DA No ive	<ul><li>13. Was Decedent of H If Yes, specify Cuba</li><li>1 ☐ Yes 2 No</li></ul>	ın, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit	
5-0036	hours at naturel" lical Ex	leted	15. Decedent's Education	Dates. 16a. D	Decedent's Usual Occup	ation	16b	Specify: 6	/Industry
121	ithin 72 lene. r then "	Completed	(Specify only highest grade completed Elementary/Secondary (0-12)  College (		Give kind of work done of 1900 NOT use retired)	1		he Boy.	's Home
${\cal N}$ Maryland 2121	permit. Pege 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath end Mental Hygiene. Important: if Item 27 is marked other then "naturel", or items 23e or 28a-f show any Injury or other traumatic event, the Medical Examirer must be notified at once.	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Maid	Surname)	erel
7 Jaryl	should be end Me		19a Informant's Name/Relationship (Type, Print)	1	Mailing Address (Street	and Number or Hyral	Route Number, City	or Tolvn, State, Zi	ip Code)
	1 and 2 of Health Item 27 other tr		1errance Hundley 20a. Method of Disposition		LanCash Disposition (Name of crematory or other place)	11/7P	i'a R	Location - City or	Town, State
altimore,	It. Pege rtment o rtant: If njury or		1 Burial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify)	n State Cernetery,	son we	st 1 <del>0130</del>	120	wirgs N	1:11s, MD
Ba	permit. Departr Importa any inje		21. Signature of Funeval Service Licens	ne_	551 Bal	to. Nat!	Pike	(2122	ervices 29)
N	Pnysician		23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on a limmediate Cause (Final		t enter the mode of dyir	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
000	Medical Examiner			o (or as a consequence of)	river tele	UNC.			YEARS
10	- ±	iner	cause. Enter Underlying	o (or as a consequence of)	):				
h	executed len and uriel-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to	o (or as a consequence of)	):				
760	certificete be or anding physicle use es the bur	edica	d						
1/1/1/ 89 ×	eath certificete be to ether the ether the physicle do for use es the burner	Physician/Medical	in the past 12 months?	utcome of pregnancy e Birth 2  Fetal death	3 Ectopic pregnance	су		23d. Date of de	elivery Day Year
e     E	D 2 0	Physic	9 Unknown 9 Unk		5 Other (specify)		_		_
eth.	Physicien: The law requires that the des this centificate has been signed by the e ral director, page 2 should be detached		Part II. Other significant conditions contributing to	_	ON Cause gi	ven in Part I.	23e. Did tobacc		o the cause of death?  Probably 4 🗆 Unknown
$\mathcal{H}$ Division of Vital Record	law requ has beel ge 2 shou	Completed by	,				24a. Was an autopsy performed	prior to	topsy findings available completion of cause of
al Re	len: The	Be Co	25. Was case referred to medical examiner?			lace of Death (Check	1 🗆 Yes 2	No 1 □ Ye	s 2 🗆 No
of Vit	y Physic er this ce	P	1 ☐ Yes 2 No 1 ☐ 27. Manner of Death 28a. Dat	Inpatient 2 ER/Outp	me of 28c. Injur	4 ∐ Nursing Hon yat 2	ne 5 🗆 Residence 8d. Describe how in	•	city) HOSPICE
sion (	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director. page 2.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	onth, Day, Year) injunction injun		Yes 2 No	8f. Location (Street	and Number or Pr	ural Pouto Number
Divis	Itel or A urs after rel Direc lled in by	al Cer	4 - Homiciae aeterminea buili	ding, etc. (Specify)			City or Town, St	ate)	
	To the Hospitel within 24 hours of To the Funeral Completely filled	Medical	29a. Certifier (Check (Check only one) (Check only one) (Check only one) (Check only one) (Certifying Nurse Practition	asis of examination and/or	investigation, in my opini	on, death occurred at t	the time, date and pla	ace, and due to the	cause(s) and manner stated.
	To the sound of th		29b. Signature and title of certifier	100 1	29c. Licens			Date signed (Mont	
2	•		30. Name and address of person who completed ca	use of death (Item 23a) (Ty		BALTIMO			
	Sta		31. Date filed (Month, Day, Year) 32.	Registrari Signatur	UTAUX,	DALIMO	re MD	CIZUL	
	Regist	rar	UCI 2 0 2012 Jan	, ,,		**			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Henry Leroy Hauer, Jr. October 2012 Medical 06:17 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Security Number **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) Baltimore, Hours (Month, Day, Year) 216-30-1361 **Director** 1 X M 2 □ F 78 Oct. 13, 1934 Usual Residence of Decedent Maryland 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Maryland Harford 1 Yes 2 XNo Fallston 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? pe ms 23a (must be Funeral 2114 Oaklyn Drive U.S.A. 21047 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, ian "natural", or ite Medical Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc þ 1 Never Married 2 X Married ☐ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) the Carcenter Building artment of Health and Mental Hygi ortant: If item 27 is marked othe injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Henry L. Hauer, Sr. Mary H. Heuer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce, Mrs. Mary Ann Hauer (Scouse) 2114 Oaklyn Drive, Fallston Maryland 21047 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial Cardens October 23 Fallston, Maryland Signature of Funeral Service Licensee , Toffrey R. R. Testeman (M01543) 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services - Bel Air 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3 Newport Drive, Forest Hill, Maryland 21050 Approximate Interval Between Onset and Death Pnysician/ Ventricular Fibrillation disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-transit Acute myocardial infarction that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) Por in the past 12 months? Pregnant at time of death Year Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, Coronary artery disease 1 Tes 2 No 3 Probably 4 Inknown 24a, Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of death? certificate 2 🔃 No 1 Tes Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: |요 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

VOI

0

M00005251

State Registrar only one)

31. Date filed (Month, Day, Year)

assie klu

2 3 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sid 2. Kharal 500 Upper Cl

32. Registrar's Signature

D63420

500 upper chesapeake Dr. Bel Air, MD 21014

29d. Date signed (Month, Day, Year)

October 19,2012

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of M	aryland / Dep			Mental Hy	giene	10 0000	
			1 State Registrar	I and	Cei	rtificate of D	Death		Reg. No. ZU	12 33988	
	Physicia		1. Decedent's Name (First, Middle,	*				2. Date of Dea	ath Day	3. Time of Death	
إإنجير	Medic Examir		Alice Heisle  4a. Facility Name (if not institution,			4b. City, Town, or	Location of Doct	October			
	Z		10001 Windstream Dr	ive, Apt 808		Columbia	Location of Deat		4c. County of Howard	Death	
	Funeral				e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		h g	9. Birthplace (State or Foreign	
	Director		212-38-4148 Usual Residence of Decedent	1 □ M 2 🕱 F	75 Yrs.	Worthis Days	Hours Iviili.	(Month, Day Sept. 27		Country)  Aryland	
	and show lat	ō	10a. State 10b. County		10c. City, Town or Lo	cation		DCPC. 21	, 1997	10d. Inside City Limits	
	Maryla 28a-f	Director	Maryland Howard	J	Columbia					1 ☐ Yes 2 🛣 No	
	a or be no		10e. Street and Number			10f. Zip Code		T	10g. Citizen of Wh	at Country?	
	th with ms 23 must	Funeral	10001 Windstream Dr			21044			USA		
10	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Marrie</li></ul>	12. Was Decedent E Armed Forces? ad 1 \(\sum \) Yes 2 \(\overline{\lambda}\)	Ever in U.S. 13. \	Was Decedent of His f Yes, specify Cuban	spanic Origin? (S) n, Mexican, Puert	pecify Yes or No- o Rican, etc.)		American Indian, White, etc.	
21215-0036	rs afte ral",	ed b	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates.	140	∣ ☐ Yes 2 🙀 No	Specify:		Specify:	White	
5-0	2 hou "natu	Completed	15. Decedent (Specify only highes		16a. Deced	dent's Usual Occupa kind of work done du	tion	ddina	16b. Kind of Busi		
12	thin 7; ane. <b>than</b> ne Me	om	Elementary/Secondary (0-12)	College (1-4 or 5	i+) life. D	O NOT use retired)		KING			
d 2	ed wil Hygie other ent, th	Be (	17. Father's Name (First, Middle, La		Behavi	oral <u>Pedia</u>		- Cina Ministr	Medica	1	
Maryland	should be file n and Mental I 7 is marked o raumatic eve	٦	Kenneth Glenn Heis	,			Alice Po	ne <i>(First, Middl</i> e, 1 11ard	viaiden Surname)		
ary	should and N is ma aumal		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street ar		_	City or Town, Stat	re, Zip Code)	
Σ	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Michael Hayes-SON			owhee Drive					
ore	ye 1 a t of H If ite or oth		20a. Method of Disposition 1 ☐ Burial 2 ← Cremation 3	B ☐ Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place	)	Date	20c. Location - Ci	ty or Town, State	
Baltimore,	it. Pag irtmen irtant: njury		4 ☐ Donation <sup>A</sup> 5 ☐ Other (Sp.	ecify)	Atlantic Cr		10/19		Glen Burn	ie, Maryland	
Ba	per nit. Page 1 De artment of Important: If it any, injury or c	E	21. Signature of Funeral Service Lic	1234	Wi	Name and Address tzke Funera 55 Twin Kno	of Facility Homes, I	NC,	MD 010/5		
			23a. Part 1. Enter the disease, or co	omplications that caused	the death. Do not ente	r the mode of dying,	, such as cardiac	or respiratory arre	MU 21045 est,	Approximate	
~ 1	Physician/		shock, or heart failure. List onl Immediate Cause (Final disease or condition	A. w.	ACIC ADEA	10000014	. 44 A DA	NOREN	<i>e</i>	Interval Between Onset and Death	
لامريب	Medical Examiner		resulting in death)		consequence of):	accide (100	QMM 14	IUCITEA	2	OTWUDEN	
		er	Sequentially list conditions,	b							
	nsit nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of);						
	executed an and irial-transi	Exa	that initiated events resulting in death) Last	Due to (or as a	consequence of);						
9	icate be executed g physician and is the burial-transit	dical		<b>=</b> pt:							
92	certificate be nding physicis use as the bu	Mec	IF FEMALE:								
×	tth cer ttendi	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 Fetal death 3	Ectopic pregnancy			23d. Date o	,	
. Box	re dea / the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death 5 ∟	Other (specify)			Month	Day Year	
J.	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions	s contributing to death bu	ut not resulting in the ur	nderlying cause give	n in Part I.	23e. Did tob	pacco use contribu	te to the cause of death?	
ŝ	uires uld be	ed b						1 □ Y	es 2 🗹 No 3[	☐ Probably 4 ☐ Unknown	
Š	iw req is bee 2 sho	plet						24a. Was a	n 24b. Wer	e autopsy findings available	
ě	The la ate ha page	Completed						autops perform	ned? deat	r to completion of cause of th? I Yes 2  No	
ta	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Lia anitali.		26. Plac	e of Death (Chec		Z III NO	7103 2 110	
Division of Vital Records,	Physi this o	욘	1 Yes 2 No 27. Manner of Death	Hospital:  1 Inpatie  28a. Date of injury	nt 2 Fr/Outpatient		4 L Nursing H	ome 5 - Reside	ence 6 - Other (S	Specify)	
_ 0	ding th. After fune	Certificate:	1 Natural 5 Pending	(Month, Day,		28c. Injury a work? M 1 🗌 Ye	at es 2 ⊡ No	28d. Describe ho	w injury occurred		
<u> </u>	Atter er dea ector by the	ij	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine	t be 28e. Place of Injur	y - At home, farm, stre		53 2 110	28f. Location (Str	reet and Number o	r Rural Route Number,	
≥	tal or rs afte al Dir led in			building, etc.	(Specify)		7	City or Town		,	
	Hospi 4 hou Funer tely fil	Medical	29a. Certifier 1	hysician: To the best of n	ny knowledge, death or	ocurred at the time, o	date and place, a	and due to the cau	se(s) and manner a	as stated. the cause(s) and manner stated.	
	ithin 2 orthe I		only one) 3 Certifying N  29b. Signature and title of certifier	urse Practitioner: To the	best of my knowledge,	death occurred at the	time, date and pl	ace, and due to the	e cause(s) and mann	ner as stated.	
	F ≥ F ö		Laurence R.	Callenn us	nits	29c. License n			9d. Date signed (M	S 2 C 1 Z	
,	$n\Omega /$	ŀ	30. Name and address of person wh	o completed cause of de	ath (Item 23a) (Time Pr	int)					
	201		LAURENCE F	2 GALLA	GER M.	D. 405 Free	derick Rd,	STE 206,	Catonsvill	e, MD 21228	
	State	Э	LAURENCE F B1. Date filed (Month, Day, Year) OCT 2 3 20	32. Registrar	's Signature	W					
	Registra		901 20 20	- Heren	p. 19		<u>-</u>				

			For State	of Maryland / Depa			giene			
			To State Registrar  Certificate of Death  Reg. No. 2							
	Physicia Media		Gary Michael Ham	ilton		Month Oct.	Day Year 11:10p M			
and the state of t	Examir		4a. Facility Name (if not institution, give street and nu Franklin Square H		4b. City, Town, or Loc Roseda	cation of Death	4c. County of Death Baltimore			
	Funeral Director	Г	5. Social Security Number 2 1 5 - 5 6 - 4 0 6 6 Sex  Usual Residence of Decedent	Hours Min. 8. Date of Bit (Month, Dan)	orth gy Year) 9. Birthplace (State or Foreign Country) North Caroli					
	aryland a-f show ified at	Director	10a. State 10b. County Baltimore	10c. City, Town or Loc	cation arney		10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
	the Man or 28		10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?			
	th with ms 23; must	Funeral	9639 Oak Summit Ro		21234		USA			
9000	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	δ	Armed F	orces? If 2 No ve 1	was Decedent of Hispa f Yes, specify Cuban, M I ☐ Yes 2 🎛 No S	unic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.)  Specify:	14. Race - American Indian, Black, White, etc. Specify: White			
21215-0036	within 72 hou giene. ier than "nati i; the Medica	Completed		(Give I	dent's Usual Occupation kind of work done durin O NOT use retired) urity Gua	ng most of working	16b. Kind of Business/Industry Allied Barton			
d 21	led with Hygier other t ent, th	Be C	12th 17. Father's Name (First, Middle, Last)	1 3000		8. Mother's Name (First, Middle,	Security Services  Maiden Surmame)			
ylan	should be filed within and Mental Hygiene. is marked other tha aumatic event, the D	မ	Henry A. Hamilton	Sr.		Margie Haym				
Maryland	2 shou Ith and 27 is m traum		19a. Informant's Name/Relationship (Type, Print)  Gavin Edwards / fr	1	-		er, City or Town, State, Zip Code) imore MD 21221			
ore,	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr		20a. Method of Disposition 1 □ Burjan 2 □ Cremation 3 □ Removal from	20b. Place of Dispo		Date Date	20c. Location - City or Town, State			
Baltimore,	permit. Page Department o Important: If any injury or once,		4 Donat on 5 Other (Specify)	Bayvie	v Cremato	ry 10/22/12				
Ba	permit. Departr Imports any inji		21. Signature Fineral Signature License	al c		Funeral Home	e Ave. Balto. MD e of Essex 21221			
	Physician/ Medical		resulting in death)	her 10 Sclex	1.	uch as cardiac or respiratory and to vascular	Interval Between			
-	Examiner		Due to	(or as a consequence of):						
	sit sit	Examiner	cause. Enter Underlying	(or as a consequence of):						
	sate be executed physician and the burial-transit		Cause (Disease or injury that initiated events resulting in death) Last C. Due to	(or as a consequence of):						
09	ate be e	edical	d							
Box 687	ath certific attending for use as	Physician/Me	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year			
	v requires that the des been signed by the should be detached	by Ph	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given i		obacco use contribute to the cause of death?  Yes 2 □ No 3 □ Probably 4 ✔ Unknown			
Division of Vital Records,	The law requires ate has been sign page 2 should bo	Completed by		-	-	24a. Was	an 24b. Were autopsy findings available			
Rec	sician: The law scrificate has b	Com				auto perfo 1 \( \sum \text{Yes}	ormed? death?			
ital'	Physician: this certific aral director,	Be	25. Was case referred to medical examiner?  1 X Yes 2 \sum No Hospital:		Other:	of Death (Check only one)				
of V	> 000	ite: To	27. Manner of Death 28a. Date	Inpatient 2 ER/Outpatien of injury 28b. Time of injury injury	DOA Other. 2  28c. Injury at work?	4 Nursing Home 5 Resi 28d. Describe I	dence 6 U Other (Specify)  now injury occurred			
sion	l or Attendii after death. Director: Af I in by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	e of Injury - At home, farm, stre	M 1 TYes	2 No	Street and Number or Rural Route Number,			
Divi	Hospital or Attending 24 hours after death. Funeral Director: After stely filled in by the fune			ing, etc. (Specify)	, idotory, omoc	City or Tov				
		Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the law Medical Examiner: On the base only one)  3 Certifying Nurse Practitione	pest of my knowledge, death o sis of examination and/or invest r: To the best of my knowledge.	igation, in my opinion, d	leath occurred at the time, date a	and place, and due to the cause(s) and manner stated			
	To the within 7 To the comple	2	29b. Signature and title of certifier	i. to the best of my knowledge,	29c. License nur		29d. Date signed (Month, Day, Year)			
	mli		30. Name and address of person who completed cau	se of death (Item 28a) (Type, P	10180	06/	October 20, 5015			
	2119	-	Philip Militello, M	6 Trub	HillCTL	- atherville, M	d 21093			
	Stat Registra		31. Date filed (Month, Day, Year) 32. F	Registrar's Signature	as a second	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 7:30 am Marjorie Lucille Hill October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Renaissance Gardens - Riderwood Silver Spring Prince George's Security Number -40-7044 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🗆 M 2 🗶 F Months Hours Days (Month, Day, Year) 10/01/1922 90 Ohio **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits rector 1 Yes 2 No Silver Spring Maryland Prince George's ٥ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20904 3160 Gracefield Road, #1513 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 Yes 2 No Black, White, etc. ş 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. 3 XWidowed 4 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne
any injury or other traumatic event "he." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Helen Lee Stauch William Arthur Hoover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11786 Ridgeway Drive, Monrovia, Maryland 21770 Sandra Anthony - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/26/2012 | Rockville, Maryland 4 Donation 5 Other (Specify) Parklawn Mem. Park 21. Signature of Funeral Service Lice is a 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 M. Neva MO162 . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
7 Years Immediate Cause (Final Pttysician/ Arteriosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence or) if any, leading to immediate cause. Enter Underlying -transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) burialphysician s the burial Physician/Medical that the death certificate be Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 X No Month Day Year Pregnant at time of death the P.O. signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Diabetes Mellitus Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate or Attending Physician; 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 XX Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA funeral ( 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Investigation the 1 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 29b. Signature and title of certifie License number 29d. Date signed (Month, Day, Year,

State Registrar 30. Name and

Julaine Harding,

3110 Gracefield Road, Silver Spring, Maryland 20904

address of person who completed cause of death (Nem 23a) (Type, Print)

2. Registrar's Signature

CRNP,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 9 per fh g933 I1-26-12 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:25 рм John Louis Hill 2012 October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death Vantage House Nursing Home Columbia Howard Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Country) AT kansas 1 X M 2 🗆 F Months Days Hours Min (Month, Day, ) 412-07-4208 Director 100 Yrs <del>Arizona</del> Usual Residence of Decedent 28a-f show 10a. State 10b. County iled within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Columbia Maryland Howard 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5400 Vantage Point Road 21044 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1943 If Yes, Give Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Tes 2 No Specify. "natural", Completed 3 Divorced Specify 1945 Year or Dates Caucasian event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Accountant Be alth and Mental H 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic es John L. Hill Lucy English 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue Reed - Daughter 2604 Sagebrush Terrace, Silver Spring, Maryland 20905 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Quantico Natl. Cem. 10/23/2012 Triangle, Virginia 21. Signature of Funeral Service Lig 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease shock, or heart failure complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Pneumonia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Month Day Year be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 24 hours after death. Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Certificate: To 1 🗆 Yes 2 🗶 No Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 To the I within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title of certifie 29d. Date signed (Month, Day, Year) (M) D47447 October 16, 2012 tol 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Andrew Lazras,

31. Date filed (Month, Day, Year)

M.D.,

3 2012

Suite 103, Columbia, Maryland 21044

6334 Cedar Lane,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-	For State Registrar	State of Maryla		epartificati			iliu ivi		Reg. No.	2012	33992	
Physiciar	,	Decedent's Name (First, Middle, Las	t)						2. Date of Dea	ath	Year	3. Time of Death	
Medica	al .	John Heffington  4a. Facility Name (if not institution, give			T., 01				October			8:50 AM M	
Examine	er	North Arundel N		ab			Burn			4c. County of Death  Anne Arundel			
Funeral		5. Social Security Number 6. Se	ial Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8.1								g. Bir	thplace (State or Foreign untry)	
Director		226-34-3144 1 Usual Residence of Decedent	X M 2 □ F 84	Yrs	3.				Oct 21	, 192	27 Vir	ginia	
/land f shov ed at	į	10a. State 10b. County	10c.	City, Town o	Location				<del>-</del>			10d. Inside City Limits	
e Mari r 28a- notifie	Director	MD Anne Ar  10e. Street and Number	unde1	S	evern	Code				10= Citie	en of What Co	1  Yes 2 X No	
with th	Funeral	112 Otis Drive			101. 21		21144				JSA	untry:	
death items ner mu		11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S.	13. Was Deced	lent of His	spanic Orig	in? (Spec	ify Yes or No- ican, etc.) 14. Race - America Black, White, e				
21215-0036 within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 🔼 Yes 2 ☐ No If Yes, Give Year or Dates.		1 🗆 Yes					Sį	iite		
15-C	Completed	15. Decedent's E (Specify only highest gra	ide completed)	(G	ecedent's Usua ive kind of wor	k done di	ation uring most	of workin	g	16b. Kind	6b. Kind of Business/Industry		
within jiene.		Elementary/Secondary (0-12)	College (1-4 or 5+)		e.DONOTuse ll dril	,				co	mmerci	al	
<b>2</b> 5 ± 5 €	To Be	17. Father's Name (First, Middle, Last)  James Edward He:	rrington	•			18. Mothe	r's Name	(First, Middle,	Maiden Su	ımame)	unk	
Aaryl should B and Me raumati		19a. Informant's Name/Relationship (T)		19b. N	lailing Address	(Street a	nd Number	r or Rural	Route Number	r, City or To	own, State, Zip	o Code)	
Ge, Mand 2 sl and 2 sl Health a tem 27 i	1	John Heffington					eet P	asad	ena, MĮ				
more		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☑ Other (Specif	Removal from State	cemetery,	sposition (Nan crematory or o	ne of ther place	9)	D	ate	20c. Loca	ation - City or	Town, State	
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other	Ì	21. Signal are of Funeral Sovice Lens	Mad, Direct	or	22. Name an	d Addres Anato	s of Facility	oard	655 W.	Balt	timore	Street	
	+	23a. Part 1. Enter the disease, or comp	olications that caused the de	eath. Do not	Baltim enter the mod	ore, e of dying	MD g, such as c	ardiac or	respiratory arr	est,		Approximate	
Physician/	ļ	shock, or heart failure. List only of Immediate Cause (Final disease or condition	Gartine.	Corr	CIMON	na						Interval Between Onset and Death	
Medical Examiner		resulting in death)	ue to (or as a conse	equence of):		2	00						
	je	Sequentially list conditions, if any leading to him ediate cause. Enter Underlying	b. Due to for as a conse	equence of):	reme	41-1	/						
ficate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events	C. Due to (or on a come	annan aft									
be exe sician a burial-		resulting in death) Last	Due to (or as a conse	equence on.									
3 7 60 ificate be ig physicials as the bu	Medical	E FEMALE.	d										
box 6 death cert le attendir ed for use		1 Live Birth 2 Fetal death 3 Lectopic pregnancy									3d. Date of del Month	livery Day Year	
that th	Ž	Part II. Other significant conditions co	entributing to death but not	resulting in t	ne underlying	ause giv	en in Part f.		23e. Did to	bacco use	contribute to	the cause of death?	
dS, quires en sig ould b	ted	Parkingen	Duere						1 🗆 🗎	Yes 2	<b>S</b> alo 3 □ Pi	robably 4 🗌 Unknown	
VItal Hecords, ysician: The law requires is certificate has been sig director, page 2 should t	Somple								24a. Was a autop perfo 1  Yes		prior to death?	topsy findings available completion of cause of	
ician:	Be	25. Was case referred to medical examiner?	Hospital:			Othe	ce of Death		only one)	7			
Of V y Phys er this	e: 10	1 Yes 2 1 106 27. Manner of Death	1 Inpatient 2	28b. Tim	e of 2	8c. Injury	4 ∟ Nur at		ne 5 🗌 Resid 8d. Describe h			ify)	
ending eath. or: Afte the fur	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		inju	M	work?	Yes 2 🗆	No					
DIVISION OF tal or Attending Pr s after death. al Director: After th ed in by the funera		4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		street, factory	, office		2	8f. Location (S City or Tow		Number or Rui	ral Route Number,	
DIVISION Of VITAI RECORDS, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	Medical	(Check 2 Medical Exami	sician: To the best of my knoner: On the basis of examina se Practitioner: To the best of	tion and/or in	vestigation, in	my opinio	n, death occ	curred at 1	he time, date a	nd place, a	nd due to the	cause(s) and manner stated.	
To t with To t		29b. Signature and title of certifier	MA		290	License	number	2		29d. Date	signed (Month $7/2e$ )	n, Day, Year)	
		30. Name and address of person who c	ompleted cause of death (It	em 23a) (Typ	e, Print)	_H	of w	WI	Sin	GA	Bur	ne MD21061	
State Registra	-	31. Date filed (Month, Day, Year)	32 Registrar's Sig	nature	barker								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Month Day 2013

AM

12:46

9. Birthplace (State or Foreign

10d. Inside City Limits

Onset and Death

1 ☐ Yes 2 🎇 No

unk

Maryland

4c. County of Death

10g. Citizen of What Country?

USA

Specify:

16b. Kind of Business/Industry

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year)

Wicamica

14. Race - American Indian,

white

Black, White, etc

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) Physician/ David C. Harrington Medical 10 -4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Salisbury Coastal Hospice at the Lake If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Director 215-62-0590 1 X M 2 □ F 57 Aug 8, 1955 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Funeral Director notified MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 9 must be 527 Alabama Avenue #17 21801 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. "natural" 3 Widowed 4 X Divorced Completed the Medical Decedent's Education 16a, Decedent's Usual Occupation (Specify only highest grade completed, Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygiene. Item 27 is marked other the other traumatic event, the I Ó electrician Be unk 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Betty Milligan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Joyce Mason/former spouse Devid 32095 Dublin Road Princess Anne, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 H Other (Specify) in Signature Funeral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director <u>Baltimore, MĎ</u> Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate cause (Final Physician/ NORA 1 NG disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): use as the burial-transi Cause (Disease or injury that initiated events and

attending physician for use as the buria signed by the at Id be detached fo page 2 completely filled in by the funeral director,

Hospital or Attending Physician: The law requires that the death certificate be to the fours after death.
 Funeral Director: After this certificate has been signed by the attending physicial

To the within 2 To the F

Division of Vital Records, P.O. Box 68760

Physician/Medical Examiner IF δ Completed Be ျှ Certificate:

Medical

resulting in death) Last	Due to (or as a consequence of):  d.			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		topic pregnancy her (s <i>pecify)</i>		23d. Date of delivery  Month Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the under	rlying cause given in Part I.		use contribute to the cause of death?
			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 ☑ No
25. Was case referred t edical examiner? 1 Yes 2 No	Hospital: 1  Inpatient 2 ER/Outpatient 3	only one)	6 Other (Specify) VOSPICE	
27. Mann → of Death  1 V Natural 5 □ Pending 2 □ Accident Investigatio 3 □ Sulcide 6 □ Could not be		ry occurred		
4 Homicide determined		28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)	
(Check 2 Medical Exam	ysician: To the best of my knowledge, death occu niner: On the basis of examination and/or investigati rse Practitioner: To the best of my knowledge, dea	on, in my opinion, death occurred at	the time, date and place	e, and due to the cause(s) and manner stated.
29b. Signature and title of certifier		29c. License number	29d D	ate signed (Month, Day, Year)

EASTERN SHURE DR

Registrar DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>4880 Jones Drive</u> Fort George G. Meade Anne Arundel Social Security Numbe **Funeral** 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Min Director 012-05-3588 1 🔯 M 2 🗆 F Yrs 95 Usual Residence of Decede Julv 17. Connecticut 27 is marked other then "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. Count death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 No Anne Arundel Fort George G. Meade 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4880 Jones Drive 20755 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 X Yes 2 No 1942-Š Black, White, etc. and 2 should be filed within 72 hours after of Health and Mental Hygiene. tem 27 is marked other then "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Completed Specify: White 3 X Widowed 4 Divorced 1977 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Staff Sergeant United States Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Hachey Christine Gionet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 4880 Jones Drive, Fort George G. Meade, MD 20755 Wayne E. Hachey/Son other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 permit. Page 1
Department of
Important: If it
any injury or o 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory Odenton, Maryland 2012 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. Will Elon M00672 Annapolis Road Odenton, Maryland 21113 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ere brom Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Error Underlying Examine Due to (or as a consequence of): signed by the attending physician and defeached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physiclen: The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sign. pege 2 should t Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physicien: The within 24 hours after death.

To the Funeral Director. After this certificate I completely filled in by the funeral director, peg perform 1 ☐ Yes 2 ☐ No Yes 2 Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 Yes 2 2 No |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manney Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and aftle of certific 30. Name and address of person who completed cause of death (Item 23a) (Ty

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Medical actobos 16. 2012 Facility Name (if not institution, give street and numb 4a. **Examiner** Town, or Location of Death 4c. County of Death Johns Hap Juspital muse Social Security Number Funeral Age (In vrs. last birthday If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months Hours 485-36-4889 **Director** 83 12/16/1928 IA 28a-f show with the Maryland 10b. County be notified at 10c. City, Town or Location Director 10d. Inside City Limits Union Young Harris GA 1 Yes 2X No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 4250 Bonny Hills Drive 30512 USA death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 0 Black, White, etc. þ 1 Never Married XXMarried Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. fant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examiury or other traumatic event, the Medical Examium or other traumatic event, the Medical Examium or other traumatic event, the Medical Examium or other traumatic event, the Medical Examium or other traumatic event, the Medical Examium or other traumatic event, the Medical Examium or other traumatic event. 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: white 3 Widowed 4 Divorced Completed Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Surgeon Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Walter Held Mary Royse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Held, wife 4250 Bonny Hills Drive Young Harris GA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetay, crematory or other place)
Laure Hills
Cemetery 1X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 10/22/12 Young Harris, 4 ☐ Donation 5 ☐ Other (Specify) GA Signature of Funeral Service Licensee 22. Name and Address of Facility Drive 7221 Grayburn Drive Name and Address of Facility Harman Funeral Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final enysician/ ISC IMIC cardionypiathy resulting in death) Medical Due to (or as a consequence of): **Examiner** corregany artery disease Sequentially list conditions, Limit (at at a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No d Pregnant at time of death 5 Other (specify) Month Day the 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of page 2 s 24a. Was an has autopsy performe death? After this certificate Yes 2 No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 🕱 No Other: ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural injury 5 Pending work? s after death.

I Director: A di in by the fu Accident Suicide Investigation 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I

comple only one) 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Joon, MI) RES-OOC October 16,2012

State Registrar 31. Date filed (Month, Day,

Imore MD 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tsao

33998

		•	1 - State Registrar Certificate of Death Reg. No.											
			1. Decedent's Name (First, Middle, Las	t)	· ·					2. Date of De			3. Time of Death	
	Physicia Medic		Marshall Barnett	Harper						Octobe	r 18	201 <sup>2</sup>	2:50 A	Л
	Examin		4a. Facility Name (if not institution, give		4c.	County of Death	1							
	,		Montgomery Hospic		Me	ontgomer	У							
-00-	Funeral		5. Social Security Number 6. Se		e (In yrs. last birti		Rockvi	If Under		8. Date of Bir (Month, Da	th		nplace (State or Foreig	n
	Director		554-96-9003	4-90-9003   1 M 2 L F   56 Vrs									ntry)	
	3		Usual Residence of Decedent							January	21, 1	956   Cal	ifornia	
	sho sho	ō	10a. State 10b. County		10c. City, Towr	or Loca	ition						10d. Inside City Limits	3
	Aaryl Ba-f	Director	Maryland Montgome	ery	Bethe	sda							1 🗌 Yes 2 ី N	ю
	or 2		10e. Street and Number				10f. Zip Code				10g. Citi	izen of What Cou	ıntry?	_
	23a	era	5415 Bradley Boul	Levard			20814				Uni	ted Stat	ces	
	ems fr.mi	Funeral	11. Marital Status	12. Was Decedent B	Ever in U.S.	13. Wa	as Decedent of H	ispanic On	gin? (Spe	cify Yes or No-		14. Race - Amer	ican Indian,	_
9	or if	by	1 Never Married 2 🛛 Married	Armed Forces? 1 X Yes 2 □			Yes, specify Cuba			Hican, etc.)		Black, White		
င္မ	s aff		3 Widowed 4 Divorced	If Yes, Give Year or Dates. 1	1981-2003	11	☐ Yes 2 🔯 No	Specify:				Specify: Wh	ite	
О	hou natu	Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a.	Decede	nt's Usual Occup	ation	s of working		16b. Ki	ind of Business/I	ndustry	
2	9	Ĕ	Elementary/Secondary (0-12)	College (1-4 or 5	5+)	life. DO	NOT use retired)	Ü	OI WOIKII	19	i .	_		
2	with gien .			5+	l I	nfan	try Off:	icer			Uni	ted Stat	es Army	
פר	ivent end	Be	17. Father's Name (First, Middle, Last)							(First, Middle,	Maiden S	Surname)		
<u>a</u>	Aents Arked Itic e	욘	Barnett Harper					Jose	ephir	ie Unk	nown			
Maryland 21215-0036	and hould		19a. Informant's Name/Relationship (Ty	pe, Print)	19b	. Mailing	Address (Street	and Numbe	r or Rural	l Route Numbe	er, City or	Town, State, Zip	Code)	
Σ	alth a		Ronda L. Schrenk	/ Wife	5	415	Bradley	Bou1e	evard	l, Beth	esda	, Maryla	and 20814	
<u> </u>	of Figure 1		20a. Method of Disposition		20b. Place of	f Disposi	tion (Name of	- (	) a # a E	per 20,	20c. Lo	ocation - City or	Town, State	
altimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: I firem 27 is marked other then "natural", or items 23a or 28a-f show eny Injury or other treumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 💢 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Montgo	mery	ntory or other place	<i>(e)</i>	201	12	  Bet1	hesda. N	faryland	
₩.	erie erie		21. Signatury of Funeral Service Licens		JOI Chia C	22	Name and Addre	ss of Facilit						
ñ	Per Per Per		Arth V		M01619	Rol	bert A.	Pumph	rey	Funeral	l Hon	ne, Rock le. Marv	ville, Inc land 20850	•
			23a. Part 1. Enter the disease, or comp	olications that caused	the death. Do n								Approximate	7
-			shock, or heart failure. List only or Immediate Cause (Final				+ - C					1	Interval Between Onset and Death	
- 1	nysician/ Medical		disease or condition resulting in death)	a	a consequence of		tic Can	cer						-
	Examiner			Due to (or as a	a consequence o	JI).								
		9	Sequentially list conditions, if any, leading to immediate	b. Due to for as	a consequence of	off:								—
7	ad Isit	듵	cause. Enter Underlying Cause (Disease or injury	240 (0.40		,-								
1	and and I-trar	Examiner	that initiated events resulting in death) Last	events c.										_
_ ;	icien burle													
68760	phys the	/Medical		d										
89	Se ag		IF FEMALE:	23c. If yes, outcome	of pregnancy							22d Date of dali		
X	attr c atten for u	ciar	in the past 12 months?	1 Live Birth 4 Pregnant a	2 Fetal death		Ectopic pregnand Other (specify)	СУ			- 1	23d. Date of deli Month	Day Year	
Ď	The law requires that the deam centricate be executed ete has been signed by the attending physicien and page 2 should be detached for use as the burlei-transit	Physician	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown			- (County							
0	ed by detac	/ Pr	Part II. Other significant conditions co	ontributing to death b	out not resulting i	n the und	derlying cause giv	ven in Part I	l.	23e. Did t	obacco u	se contribute to	the cause of death?	
	signe Signe d be	d by								1 🗆	Yes 2	□ No 3 □ Pr	obably 4 🕅 Unknow	/n
ğ	ned n	ete								045 19/55		24b Mars out	anny findings available	_
O O	law hast	Completed								24a. Was auto		prior to c death?	opsy findings available ompletion of cause of	
ž į	cete ; pag	ပိ								1 ☐ Yes			2 🗌 No	
ta [	cian sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:				ace of Deat		, ,			1	
<b>5</b>	this c	욘	ILI Yes 2 AJ No	1 🗆 Inpati	ent 2 ER/Ou			4 ⊔ Nı					<sub>W</sub> Hospice	_
0	Miter i	ate	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of inju (Month, Day	ry 28b. i y, Yea <i>r</i> ) in	Time of njury	28c. Injur work		- 1	28d. Describe I	now injury	occurred		
ō	teath tor: /	ific	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be					Yes 2 □	-					_
Division of Vital Records, P.O. Box	in by	Certificate:	4 Homicide determined	28e. Place of Inju building, etc		rm, stree	t, factory, office		1	28f. Location (3 City or Tov		d Number or Run	al Route Number,	
ā ;	urs a		W -											- 1
3	Fune Fune fely	Medical		ner: On the basis of e	xamination and/o	r investig	ation, in my opinio	on, death oc	curred at	the time, date a	and place,	and due to the c	ause(s) and manner sta	ted.
4	in the hospital of Attending Priysician: The law within 24 hours after death.  To the Funerel Director: After this certificate has a completely filled in by the funeral director, page 2 and a completely filled in by the funeral director, page 2 and a completely filled in by the funeral director.	ž	only one) 3 Certifying Nurs  29b. Signature and title of certifier	e Practitioner: To the	e best of my know	wledge, d	leath occurred at t 29c. Licenso		te and pla	ce, and due to				
, j	<b>₽ ≥ ₽</b> 8		250. Signature and the of certifier									e signed (Month)		
			Bank				D0060	J034			UC	tober 18	2012	
14			30. Name and address of person who c					D = -1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	lo Mar-	<sub>17</sub> 1 ~~	4 200EF		
11			Bindu Joseph, M.I				.11 Road	, KOCI		le, Mar	утап	u 20033		
	Stat	e ar	31. Date filed (Month, Day, Year) OCT 2 3 20	12 A. Hegistra	ar's Signature	bar	Kal							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month : Iliam Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death His 1 9000 R Social Security Number 6 Sex 7. Age (In yrs. last birthday, If Under **Funeral** Date of Birth 9. Birthplace (State or Foreign Birthpie Country) Hours (Month, Day, Year) 02/13/1943 Min. 007-40-1310 **Director** 69 1 □**X**M 2 □ F 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified Montgomery MDBethesda 28a-f 1 Yes 2 No 10e. Street and Numbe ŏ 10f. Zip Code must be r 10g. Citizen of What Country? Funeral Grosvenor Lane 20814 5721 USA and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Givઍietnam Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or iten edical Examiner 14. Race - American Indian, þ Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: Completed 3 Widowed 4 X Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Disabled event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. ည William J. Harms Mary Ann Hopp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Mary Ann Epstein Sister 6012 Lochan Ora Lane Manassas VA 20111 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Atlantic Crem 10/20/12 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) e of Fy eral Service Licenses 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Immediate Cause (Final Cont Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** 00 Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ ξō in the past 12 months? Month Pregnant at time of death Day Year signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 Yes 2 No Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No ပ ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) this Division of 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1 Natural  $5 \square$  Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Could not be after death Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined ospital within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of contiller Name and address of person who completed cause of death (Item 23a) (Type, Print) Jacqueline Smith 31. Date filed (Month State Registrar

ORIGINAL

William

H DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Charles Lester Hamlin State of Maryland / Department of Health and Mental Hygiene 2012 33998 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Charles Lester Hamlin Month Day October 18, 2012 **Medical Examiner** 2152 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3600 West Franklin Street # 5D Baltimore 5 Social Security Number **Funeral** 7. Age (in yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 217-56-5739 Months Days Director Hours Min. 1 XM 62 10/18/1950 2\_\_\_ F Country) MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore imore, MD 21215-0036

Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3600 West Franklin Street #5D 21229 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No 14. Race - American Indian, Black, Armed Forces? 1 Never Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 Married White, etc. Yes 2X No Black 4 X Divorced If Yes, Give Year 1 Yes 2X No specify: Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Disabled 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) John Hamlin Carrie Marshall 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chelsea Scott Daughter 3031 Rayner Ave Baltimore MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Atlantic Crem 10/22/12 Glen Burnie MD 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line /Medical Between Onset and a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. ner if any leading to immediate Due to (or as a consecuence of) cause. Enter Underlying Cause Exam (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Physician/Medical X UNPENDED AMENDED 23a, pt. II, 27, per me, g933 11-5-12 sm of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month past 12 months? Day Year Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>á</u> 1 Yes 2 No 3 Probably 4 Unknown Asthma Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene 1 Yes 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 28f. Location (Street and Number or Rural Route Number, City Could not be or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 19, 2012 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) QCT 2 3 2012 Registrar's Signat Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 3000 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 29° 2012° CHARLES POMEROY IVES 10:00AM IIIMedical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 802 Kingston Road Baltimore Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Days 1**XX**M 2 □ F Months Hours Min New Jersey 0377674949 63 **Director** 141-40-5269 Usual Residence of Decedent items 23a or 28a-f shov er must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2/1 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 USA 802 Kingston Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 A No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ural", or iten 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 XX Never Married 2 Married 2 1 ☐ Yes XX No Specify. "natural", Completed 3 Divorced 4 Divorced White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Telecommunications Specialist State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important; If item 27 is marked of any injury or other traumatic eve Paul Pomeroy Ives Elinor Pitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Father 802 Kingston Road Baltimore, Maryland 21212 Paul Pomeroy Ives 20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 10/26/2012 Pikesville, Maryland Donation 5 Other (Specify) nature of Funeral Sery 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ather sclenke CANdin WARELIN disense Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Por Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown Year ed by the a 9 Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by DiAhetes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe 2 No 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

P.O. Hospital or Attending Physician: The law requires 24 hours after death. Division of Vital 24 hours after death.

Funeral Director: After completed filled in by To the P within 2

Maryland 21215-0036

Baltimore,

Ve State

Registrar

Medical

29a. Certifier

only one)

29b. Signature and title of certifier

AWTENCE BOAS IN > 54 Scott Adam Road Cockeysville MD 21030 31. Date filed (Month, Day, Year) 0CT 2 3 2012 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2 Sent

🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

10/23/12

29c. License number

D1587

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ 0647 Paul Jacoby 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital 8. Date of Birth . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Hours 150-38-8455 Director 66 New Jersey June 30.1946 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City. Town or Location death with the Maryland Director Page 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hyglere, and the first man the 23 are 28a-fs surt. If team 27 Is man ted other than "natural", or Itema 23a or 28a-fs up or other traumatite event, the Medical Examin or must be notified. 1 ☐ Yes 2X No Rockville Maryland Montgomery 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral U.S.A. 20850 716 Wilson Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black White etc. ۾ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4 or 5+) Law Firm Lawyer 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Nancy Belle Baker Leanard Jacoby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 716 Wilson Avenue, Rockville, Maryland 20850 Ruth Neal Jacoby - Spouse Important: If item 2 any injury or other tonce. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖒 Cremation 3 ☐ Removal from State Lincoln Crematory 10/22/2012 Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Priysician/ disease or condition resulting in death) malianant Medical Due to (or as a consequence of) Examiner eroscleratic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of or Attending Physician: The law requires thet the death certificate be executed for use as the buriai-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) been signed by the s should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s • Hospital or Attending Physician: The 24 hours after death.
• Funerel Director. After this certificate is feunerily filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) 8 Other: 4 \( \bigcap \) Nursing Home 5 \( \bigcap \) Residence 6 \( \bigcap \) Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မူ 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Hornicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Rockville medical Wenk MD an 31. Date filed (Month, Day, Year) QCT 2 3 2012 32. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

490